The negotiation of HIV prevention among community HIV educators in KwaZulu-Natal, South Africa

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In loving memory of

Laurens van der Graaff

(21 May 1984 – 17 July 2014)

Your journey abrubtly ended on board of flight MH17. It is for you that I finish this thesis. If only I could run into you on my way to the submission office, just like it happened when I submitted my MA thesis in Amsterdam. How I would love to see that proud look on your face again. One of many warm memories I will forever hold close to my heart.

"Kwasukesukela!"
(Can I please have your attention?)

"Cosu inyama iyacosuka"
(Please share your story)

"Once upon a time there was a group
of community HIV educators"

"Sayibamba ngogozwane"[1]
(Please tell us more, we are listening)

[1] A Zulu folk tale is often started with these sentences

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Acronyms

ABC	Abstain, Be faithful, Condomise
AIDS	Acquired Immunodeficiency Syndrome
ANC	African National Congress
ARV	Antiretroviral
AZT	Zidovudine
CD4	Cluster of Differentiation 4 (a type of white blood cells that organise the immune system's response to infections)
CDC	Centers for Disease Control and prevention
CGE	Commission on Gender Equality
COSATU	Congress of South African Trade Unions
GRIDS	Gay Related Immunodeficiency Syndrome
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HRC	Human Rights Commission
HSRC	Human Science Research Council
IFP	Inkatha Freedom Party
MMC	Medicines Control Council
MSF	*Médecins Sans Frontières (*Doctors Without Borders)
MTCT	Mother To Child Transmission
NACOSA	National AIDS Coordinating Committee of South Africa
NGO	Non Governmental Organisation
NVivo	Qualitative data analysis computer software
PEP	Post Exposure Prophylaxis
RDP	Reconstruction and Development Programme (low cost government housing)
RHRU	Reproductive Health Research Unit
SIV	Simian Immunodeficiency Virus
STD	Sexually Transmitted Diseases
TAC	Treatment Action Campaign
TB	Tuberculosis
UDF	United Democratic Front
UNAIDS	Joint United Nations Programme on HIV and AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
ZAR	South African Rand

Glossary

The following is a list of *isiZulu* words used in this thesis. When looking up *isiZulu* words in the dictionary the words are listed according to their stem, for instance *bizo* instead of *imbizo* and *soma* instead of *ukusoma*.

(u)baba	father
(u)bhuti	brother
(im)bizo	gathering of people
(u)cansi	literally sleeping mat, used to imply sex
(uku)cela	formal betrothal
(uku)cumbazana	fondling and body to body rubbing
(in)duna	headman
(isi)febe	prostitute, also a woman having multiple partners
(i)gogo	grandmother
hawu!	expression of surprise
(i)hlawulo	damages
(um)hloli	examiner
(uku)hlolwa kwezintombi	virginity testing
hlonipha	expressing respect through avoidance
(u)jeqe	steambread
jola	casual relationship, Jokes On Love Affairs
kakhulu	very much
khomanani	caring together
(um)khongi	negotiator
(i)/(ama)khosi	chief(s)
khutele	hard working
kilela	verbal trappings
lobolo	bride wealth
(um)lungu	white person
makhwapheni	literally under the armpit, meaning secret lover
makoti	newly married woman, also used as girlfriend
mam	mother
mfecane	extensive period of warfare
(i)mpepho	incense
(i)mpi	army
(u)muthi	medicine
(u)muthi wentando	love medicine
ngiyabonga	I thank you
ngiyakuthanda	I love you
ngiyaphila	I am fine
(i)nkomo kamama	mother's cow
(um)numzana	respected head of the family
nyama enyameni	eating sweets with the wrapper on

phelezela	escort or accompany
(u)phuthu	thick maize meal porridge
(ama)qabase	comrades
(uku)qhenya	show pride
(i)/(ama)qhikiza	girl of marriageable age in the role as peer advisor
(uku)qoma	choose a lover
sangoma	spiritual healer
sawubona	hello
(uku)shela	propose love
(uku)shikila	expose buttocks
(isi)shimane	a man who is not successful in courtships
sisi	sister
(i)soka	a young man popular with women
(i)soka lamanyala	a man with many sweethearts
(uku)soma	intercrural sex
(uku)teketisana	sexual fantasy accompanied by love talk and praise
(isi)thunzi	dignity
(isi)tolo	store
toyi-toyi	a dance step characterized by high-stepping movements, typically performed at protest gatherings or marches
(u)tshwala	sorghum beer
ukwenda	marriage, to get married one has to make a long journey
umkhosi wo mhlanga	Zulu royal reed dance
unjani	how are you
(im)vulamlomo	the ‘mouth opener’ paid prior to marriage negotiations
yebo	yes

Abstract

This thesis is an ethnographic study of the lives of thirty community HIV educators in KwaZulu-Natal, South Africa. Compared to quantitative studies this is a small number, but by keeping the number of participants small it has been possible to obtain an extensive understanding of the lives of each individual, which helps to explain why they make the decisions they do. The reason for choosing community HIV educators as the participants in this study is because it could be stated from the outset that they are well-informed about HIV prevention and, depending on the specific NGO they work for, they have been recipients of either 'female empowerment' or 'responsible masculinity' programmes. This is significant because early HIV prevention interventions have assumed that providing individuals with HIV awareness and gender equality programmes would lead to the implementation of HIV preventative behaviour. Studying the willingness and ability to implement HIV prevention practices of these particular individuals could therefore help to answer the question whether HIV awareness and gender-related programmes are indeed sufficient to create HIV preventative behaviour change. Furthermore, it was useful to hear from these participants what they experience as enabling and restricting factors when it comes to implementing HIV preventative behaviour. The core research question is: How do community HIV educators in KwaZulu-Natal negotiate HIV prevention in their everyday intimate relationships? The data presented in this thesis was collected during ten months of participant observation amongst community HIV educators whilst they were at work, at home, or out with their peers. To further aid the general understanding of Zulu culture, the researcher lived as part of a Zulu family for six months. The thesis presents several examples of community HIV educators who do not consistently use condoms in their everyday lives despite the fact that they promote the use of condoms. How is it possible that those who speak of being transformed as a result of HIV awareness and female empowerment or responsible masculinity programmes, and who promote condom use in their communities, do not always consistently use condoms in their personal lives? This thesis is concerned with trying to resolve this apparent illogicality. It argues that when individual interventions fail to lead to behaviour change it is because individuals act in relation to other people instead of in isolation. The thesis draws on the work of Bourdieu, particularly his concepts of habitus, field, and capital, to explain how structural factors influence individual practice. This means that the negotiation of HIV prevention is affected by what is generally considered appropriate in terms of existing dispositions. Hence the perception of a particular HIV prevention practice as either

appropriate or inappropriate affects the ability of an individual to implement this practice. Examples are provided of how, when it comes to the practice of condom use, which has generally been perceived as inappropriate, structural factors have a restricting effect on HIV prevention. This thesis also provides examples of how, when it comes to the practice of medical male circumcision and virginity testing, which have generally been perceived as appropriate, structural factors actually have an encouraging effect on HIV prevention. As a result this thesis argues that instead of addressing individuals, HIV prevention interventions should address the collective. However, this thesis also argues that an increase in economic, cultural, social, and symbolic capital can suppress the effect of structural factors. To support this argument the thesis attends to individuals who, when they can afford to do so as a result of having capital at their disposal, deviate from collectively determined ideal practice, for example by discreetly negotiating HIV counselling and testing with their sexual partners.

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Now that the last few changes have been made to this thesis it is time to express my gratitude to the people who have helped me to get to this point.

First and foremost I would like to thank the people in KwaZulu-Natal, starting with the two exceptional women who set up their own NGOs to bring people together and address the issue of HIV in their communities. I am grateful for the opportunity I had to get to know you and learn from you. I salute you both. I would also like to thank the community HIV educators who have taken central stage in this thesis. You have shared your meals, houses, and stories with me. You had the patience to answer my questions, every single one of them, trusting me to treat your information respectfully. I sincerely appreciate the connection we made and I have the deepest respect for you all. Finally, I would like to thank the family who hosted me during my stay in Faras. You cared for me like I was your daughter and I will always be grateful for your hospitality. *Ngiyabonga kakhulu!*

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parts of this thesis, and to Richard and Chantell for (amongst many other things) the technological support. Now that the thesis is done I can perhaps make a trip to the North Island again, I can pick you up to visit the Ngatimoti festival, I can join you for a walk to watch the sunrise from Mount Arthur, and I can sign us up for those cycle races we talked about.

There are also two friends back in the Netherlands I would like to give special mention. I met both of you during my first year at the University of Amsterdam and you have never ceased to inspire me since. Seeing that the three of us all signed up for a PhD, we always have more than enough to talk about, yet too little time to actually do so. Nevertheless our friendships have never faded. Johannes, thank you for your great friendship and I hope that one day we can work on a project in Africa together. Klaartje, thank you for always being there for me, for being the most honest and supportive friend I could have ever wished for, and for sending me that parcel filled with Dutch licorice and the 'yogi man' to overcome the last PhD hurdles.

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the many stories my parents shared with me that no longer have a place in current society. Instead, roughly twenty years later the topic was still relevant, and I became involved in studying HIV prevention in South Africa. I would like to thank you both for the example you have set for me, for your tireless support, for your love, and for your encouragement.

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Forever indebted to you all,
Eva – Lungile – Maureau
Christchurch, December 2014

Chapter 1: Introduction

1.1 Introduction

Reflecting upon South Africa's high HIV prevalence yet inconsistent condom[2] use, Campbell asked: "why is it that people knowingly engage in sexual behaviour that could lead to a slow and painful premature death?" (Campbell, 2003: 1). When I started this research I was wondering the same thing. I found it hard to comprehend why anyone who had sex in KwaZulu-Natal, where HIV statistics were exceptionally high, would do so without using a condom. As an HIV researcher in South Africa, I could no longer think of sex without immediately thinking of HIV transmission. Furthermore, as a result of most of the literature on HIV prevention repeating the 'safe sex' discourse, I considered the use of condoms as *the* strategy to prevent HIV. I wondered what it meant that despite the clear risk, people in KwaZulu-Natal did not consistently use condoms. I initially believed that this had to indicate an indifference towards HIV prevention. However, over time I came to realise just how ethnocentric my assumptions had been. As Leclerc-Madlala puts it:

> As HIV experts, we often ask ourselves how long it will be before all the millions of people living high-risk lives, many of whom have reportedly high levels of HIV/AIDS knowledge, actually start to 'get it' and change their behaviour. Perhaps we are the ones who need to 'get it' and change our approach (Leclerc-Madlala, 2011: 786).

Without fully understanding what is happening 'on the ground' even the best intentioned attempts to stem the tide of HIV will have little impact (Campbell, 2003: 1). It is important to open our eyes to the reality of the participants' lives. Not only did I become aware of the restricting influence of structural factors on individual practice, but throughout my research I also became aware of the alternative strategies applied by the participants to reduce the risk of HIV transmission. This clearly illustrated that the participants *did* want to prevent HIV transmission.

This thesis is an open-minded study of HIV prevention strategies, primarily within long-term relationships. The core research question is: How do community HIV educators in

[2] To clarify: the condoms referred to in this thesis are male condoms. Although female condoms are available at certain sites, their use is less common and they were rarely mentioned by the people who participated in this study.

KwaZulu-Natal negotiate HIV prevention in their everyday intimate relationships? This thesis is not about numbers; instead it takes a close look at thirty individuals. By describing their personal stories in great detail I hope to make them come to life on paper, and for the reader to get a feel for the context in which the sexual behaviour of these community HIV educators takes place. I hope that the reader is able to change his or her outlook, just as mine changed during my time in KwaZulu-Natal, and subsequently is able to understand why these thirty individuals in KwaZulu-Natal make the decisions they do.

1.2 HIV/AIDS, the basics

In 1981 the Centers for Disease Control and Prevention (CDC) in the USA reported the occurrence of pneumonia without identifiable cause in gay men in Los Angeles. They spoke of Gay Related Immunodeficiency Syndrome (GRIDS), because the disease indicated a problem with the immune system and they thought that only homosexual men could become infected. However, in 1982 the same symptoms were found among intravenous drug users, haemophiliacs and Haitian immigrants in the USA (Abdool Karim & Abdool Karim, 2005: 32, 33; Squire, 2007: 25). Furthermore, medical staff in Africa recorded the same symptoms amongst their heterosexual patients (Barnett & Whiteside, 2006: 31). Consequently the name GRIDS was changed into Acquired Immunodeficiency Syndrome (AIDS) in 1982 (Abdool Karim & Abdool Karim, 2005: 32, 33; Squire, 2007: 25).

A year later, in 1983, Dr Gallo and Dr Montagnier, independently of one another, identified the Human Immunodeficiency Virus (HIV) as the virus that causes AIDS. Due to this finding it became possible to find out if someone was HIV positive by testing their blood (Abdool Karim & Abdool Karim, 2005: 32, 33; Squire, 2007: 25). In a search for the origins of HIV, stored blood samples were tested. The oldest positive results were found in blood samples taken in 1959 in Belgian Congo (now Democratic Republic of Congo). This has led to assumptions that the virus started in Africa. It is believed that HIV derives from the Simian Immunodeficiency Virus (SIV) found in chimpanzees. It is estimated that the virus moved from chimpanzees to humans in West Africa in the 1930s. How this happened is yet to be determined, but what is clear is that it has not been a single isolated event, but has happened on several occasions (Abdool Karim & Abdool Karim, 2005: 114; Barnett & Whiteside, 2006: 40; Hooper, 2000: 129, 130).

The first people known to have died of AIDS in South Africa were two air stewards, who died in Pretoria in 1982 (H. Phillips, 2012: 115). They were infected with HIV subtype B which is common in the USA and Europe. For this reason, it is assumed that they had

acquired the virus outside Africa. In the first years of the HIV epidemic in South Africa, the epidemic was mainly driven by homosexual transmission. Studies among heterosexual communities in South Africa in those early years indicate a prevalence of almost zero. Only three men tested HIV positive in a study conducted among 29,312 mine workers in 1986 (Abdool Karim & Abdool Karim, 2005: 31, 55, 115). However, soon after this research was conducted the situation started changing and HIV subtype C entered South Africa from surrounding African countries through migrant labourers working in Johannesburg (H. Phillips, 2012: 114). As of 1991 HIV in South Africa was mainly heterosexually transmitted (Abdool Karim & Abdool Karim, 2005: 31, 55, 115; H. Phillips, 2012: 115).

Compared to other pathogens, HIV is relatively hard to transmit (Hunter, 2010: 24). HIV infection requires sufficient quantities of contaminated body fluids to enter the bloodstream by passing through an entry point in the skin or mucous membranes (Barnett & Whiteside, 2006: 32). It often takes frequent and sufficient contact with HIV for infection to occur (Mays, Albee, & Schneider, 1989: 311). The main modes of transmission are sexual contact, blood transfusions, use of contaminated needles, needle stick injuries, and mother to child transmission; in the womb, during delivery, or through breast feeding (H. Phillips, 2012: 113). Figure 1 illustrates that during vaginal penetration it is easier for men to pass on the virus than it is for them to become infected. It also shows that direct blood contact is riskier than sexual exposure. Figure 2 demonstrates the large risk of an HIV positive mother infecting her baby, a risk that can be significantly reduced by medical intervention prior to and post-delivery.

Sexual exposure:	
Vaginal penetration male to female	Between 1:200 and 1:2000
Vaginal penetration female to male	Between 1:700 and 1:3000
Anal penetration	Between 1:10 and 1:1600
Medical exposure:	
Blood transfusion	95:100
Needle sharing	1:150
Needle stick	1:200

Figure 1: Table indicating risk of HIV infection through sexual and medical exposure (Barnett & Whiteside, 2006: 41)

Mother to child exposure:	
Without intervention	Between 20: 100 and 45:100
With intervention	Less than 2:100

Figure 2: Table indicating risk of HIV infection through mother to child exposure (WHO, 2010: 6)

Once HIV enters the bloodstream it destroys a person's immune system. The virus penetrates and takes over CD4 cells (a type of white blood cells that organise the immune system's response to infections). From the outside these cells still resemble CD4 cells, which is why the body's defence mechanism is unaware of the threat. When a person has just been infected, the virus cannot yet be detected. Nevertheless, at this stage a person is particularly infectious (Barnett & Whiteside, 2006: 32, 33). After this initial violent attack the body stabilizes and people become less infectious. However, the virus gradually continues to destroy CD4 cells. A healthy person's CD4 count is on average around 1200. It usually takes between 6 to 10 years before the virus has caused the CD4 count to drop down to 200. When the CD4 count is below 200, HIV turns into AIDS and the immune system will have difficulty fighting off even mild infections. Once this stage is reached a person who goes without treatment is likely to die in the next 12 to 24 months as a result of an opportunistic infection, like tuberculosis (TB), pneumonia, influenza or meningitis. There is no cure for AIDS, but antiretroviral treatment (ARVs) can restore the CD4 count. In a way these ARVs have turned HIV into a chronic illness. However, as a result of drug resistance ARVs only work for a limited time (Barnett & Whiteside, 2006: 34; H. Phillips, 2012: 111, 113).

1.3 HIV prevalence statistics

Figure 3-5 picture how Africa and in particular Sub-Saharan Africa has been hit the hardest by the HIV epidemic (Barnett & Whiteside, 2006: 140).

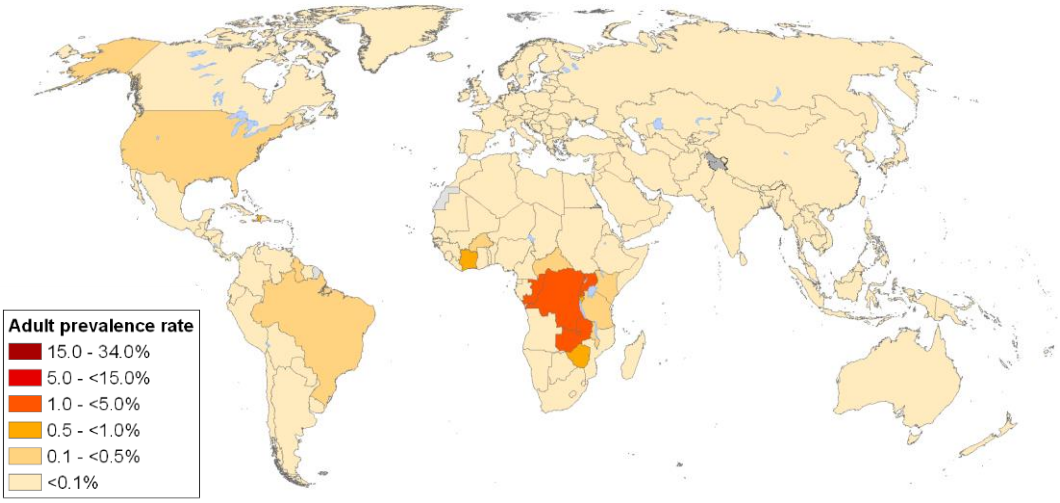

Figure 3: Map indicating adult (15-49) HIV prevalence rate (%) in 1985 (WHO/UNAIDS, 2006a)

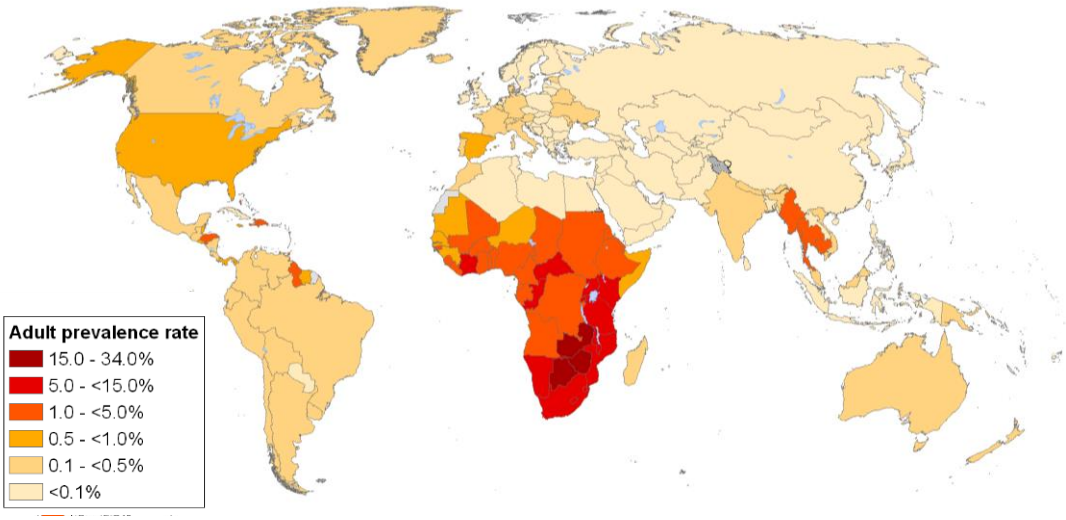

Figure 4: Map indicating adult (15-49) HIV prevalence rate (%) in 1995 (WHO/UNAIDS, 2006b)

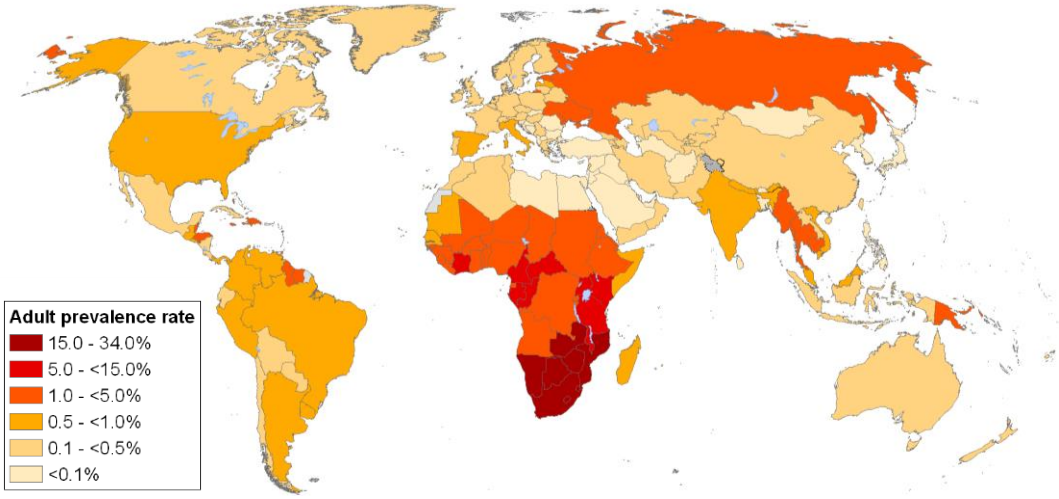

Figure 5: Map indicating adult (15-49) HIV prevalence rate (%) in 2005 (WHO/UNAIDS, 2006c)

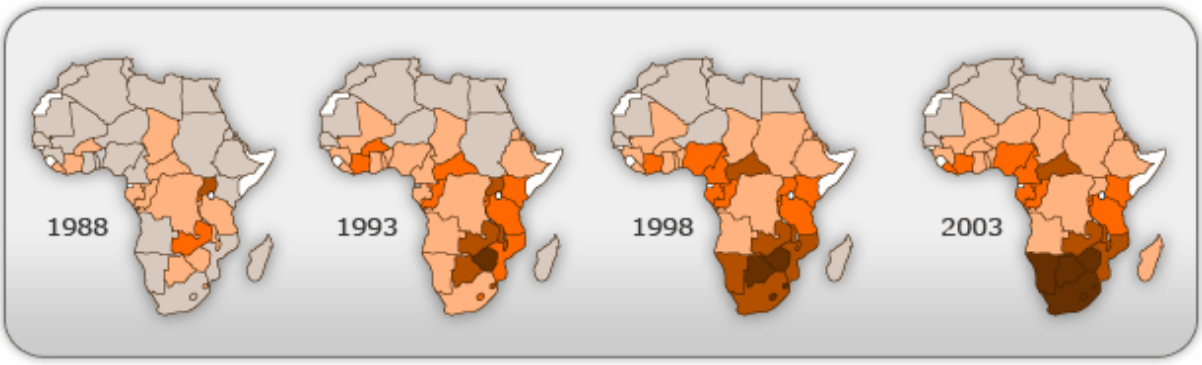

Figure 6: Map indicating HIV prevalence, the darker the colour, the higher the HIV prevalence (Avert, 2014a)

Year	WC Western Cape	EC Eastern Cape	NC Northern Cape	FS Free State	KZN KwaZulu Natal	MP Mpuma langa	LP Limpopo	GT Gauteng	NW North West	National
1990	0.1	0.4	0.2	0.6	1.6	0.4	0.3	0.7	1.1	0.7
1991	0.1	0.6	0.1	1.5	2.9	1.2	0.5	1.1	6.5	1.7
1992	0.2	1	0.7	2.9	4.5	2.2	1.1	2.5	0.9	2.2
1993	0.6	1.9	1.1	4.1	9.5	2.4	1.8	4.1	2.2	4
1994	1.2	4.5	1.8	9.2	14.4	12.2	3	6.4	6.7	7.6
1995	1.7	6	5.3	11	18.2	16.2	4.9	12	8.3	10.4
1996	3.1	8.1	6.5	17.5	19.9	15.8	8	15.5	25.1	14.2
1997	6.3	12.6	8.6	20	26.9	22.6	8.2	17.1	18.1	17
1998	5.2	15.9	9.9	22.8	32.5	30	11.5	22.5	21.3	22.8
1999	7.1	18	10.1	27.9	32.5	23.8	11.4	23.8	23	22.4
2000	8.7	20.2	11.2	27.9	36.2	29.7	13.2	29.4	22.9	24.5
2001	8.6	21.7	15.9	30.1	33.5	29.2	14.5	29.8	25.2	24.8
2002	12.4	23.6	15.1	28.8	36.5	28.6	15.6	31.6	26.2	26.5
2003	13.1	27.1	16.7	30.1	37.5	32.6	17.5	29.6	29.9	27.9
2004	15.4	28	17.6	29.5	40.7	30.8	19.3	33.1	26.7	29.5
2005	15.7	29.5	18.5	30.3	39.1	34.8	21.5	32.4	31.8	30.2
2006	15.1	28.6	15.6	31.1	39.1	32.1	20.6	30.8	29	29.1
2007	15.3	28.8	16.5	31.5	38.7	34.6	20.4	30.5	30.6	29.4
2008	16.1	27.6	16.2	32.9	38.7	35.5	20.7	29.9	31	29.3
2009	16.9	28.1	17.2	30.1	39.5	34.7	21.4	29.8	30	29.4
2010	18.5	29.9	18.4	30.6	39.5	35.1	21.9	30.4	29.6	30.2
2011	18.2	29.3	17	32.5	37.4	36.7	22.1	28.7	30.2	29.5
2012	16.9	29.1	17.8	32	37.4	35.6	22.3	29.9	29.7	29.5

Figure 7: Table indicating HIV prevalence (%) in antenatal clinic attendees between 1990 and 2012 (Abdool Karim & Abdool Karim, 2005: 56; Avert, 2014b; Department of Health, 2013: 20)

Figure 6 and 7 above portray how the HIV epidemic in South Africa had a slow start; in 1990 the prevalence was still under 1%. At this stage people even believed that maybe HIV in South Africa would not have the big impact it had in the countries north of South Africa (Beinart, 2001: 334). However, in the nineties HIV in South Africa grew exponentially to the

extent that over the past ten years South Africa has been the country with the largest number of HIV infections in the world (Abdool Karim & Abdool Karim, 2005: 31; Marks, 2002: 16; UNAIDS, 2012b: 9).

1.4 Explanations for the sudden and fast spread of HIV in South Africa

The statistics described above lead to the question: what is it about Africa and South Africa particularly, that places people at increased risk of HIV? This question has seen some racist responses about alleged exotic African sexual practices; profiling African men, once again, as savages who cannot control themselves and have rampant unruly sex (Hunter, 2010: 25; Posel, 2005: 142-148; Squire, 2007: 42; Thornton, 2008: 172). These claims have been successfully undermined by several authors.[3] Following on from their work, chapter five of this thesis demonstrates that prior to western intervention, Zulu sexuality was far from exotic: instead, sexuality was strictly monitored as youth were closely guided through puberty. It was only as a result of western intervention that these structures were compromised, leading to a breakdown of social control. Instead of the racist explanations, the following section describes the political, historical, economical, geographical and social factors that in my opinion have facilitated behaviour that places people at increased risk of HIV infection in South Africa and more particularly in KwaZulu-Natal.

1.4.1 The government's confusing response to the HIV epidemic

The first factor in explaining the high rates of HIV infection in South Africa was the weak response by the South African government to the emerging epidemic. During the late eighties, the nineties, and even the first years of the 21st century, their response has been lacking in funding, commitment, and clear leadership, which resulted in confusion amongst the population regarding the nature, causes and prevention of HIV and AIDS.

When the HIV epidemic first entered South Africa the all-white National Party was in power. Their response, or rather lack of response, has been highly criticised (Patterson, 2005; Vliet, 2001). Several suggestions circulate as to why either the National Party was reluctant to respond or their response went unnoticed. It has been argued that the National Party cared little about the epidemic because it was mainly affecting the gay and the African population (Vliet, 2001: 153). Patterson claims that AIDS policies during the Botha and De Klerk administration were shaped by: "early denial, lack of funding, little political will, and

[3] Spronk (2006), Bujra (2000), E. C. Green and Herling Ruark (2011), Reid and Walker (2005), Stillwaggon (2006), Squire (2007), Thornton (2008), Posel (2005), Hunter (2010).

puritanical racist attitudes" (Patterson, 2005: 134). Theories like these were fuelled by racist comments made by, for example, MP Clive Derby-Lewis in 1989: "If AIDS stops black population growth, it would be like Father Christmas" (Vliet, 2001: 153-156). The second suggestion circulating is that the government was reluctant to promote the use of condoms, because they believed this encouraged promiscuity. It was not until 1993 that the government allowed limited condom advertising on late night TV (Jochelson, 2001: 175). The final argument is that education campaigns had difficulty reaching their audience. Any efforts made by the government were largely ignored due to the political struggle going on at the time. In those years anti-apartheid activists had encouraged the community to resist anything suggested by the government in order to make the homelands and the townships ungovernable. It was not only due to resistance; the African population had also grown highly suspicious of the methods suggested by the government (Vliet, 2001: 154, 155). They wondered if the promotion of condoms was merely an excuse for the National Party to control the birth-rate among the Africans (Varga, 1997: 54; Vliet, 2001: 156). This is discussed more fully in chapter seven. In 2004 former President De Klerk explained that before 1994 his Health Minister did have a detailed action plan to deal with HIV, but it remained unused because "anything from the apartheid era was somehow or other contaminated" (Abdool Karim & Abdool Karim, 2005: 375).

During these early years the African National Congress (ANC) did not fill the gap by providing HIV awareness either. The ANC was too occupied fighting the political struggle to consider the threat of AIDS. To guarantee votes, they avoided the unpopular message of safe sex. Instead they focused on what they considered the voters would experience as more pressing issues, such as violence, unemployment, housing and education. Another explanation given for the ANC's limited response to AIDS was the fact that near the end of apartheid 40,000 ANC exiles were returning from regions with high HIV infection rates. In a desperate attempt to avoid the downfall of apartheid, supporters of the National Party had identified these returnees as terrorists that brought HIV to South Africa. The ANC was said to be worried that too much attention to the AIDS issue could lead to a resistance towards these returnees (Jochelson, 2001: 169, 173; Vliet, 2001: 157-159).

With the new government established in 1994 national funding for AIDS grew quickly (Abdool Karim & Abdool Karim, 2005: 376; Vliet, 2001: 161). The health plan that was created by the National AIDS Coordinating Committee of South Africa (NACOSA), an umbrella body in which the ANC, United Democratic Front (UDF), Inkatha Freedom Party

(IFP), Congress of South African Trade Unions (COSATU) and AIDS activists worked together, was implemented as the National AIDS plan by the new Department of Health in 1994 (Abdool Karim & Abdool Karim, 2005: 373, 375; Schneider, 2002: 146; Vliet, 2001). Also in that year the state funded a successful edutainment TV programme called 'Soul City' (Thornton, 2008: 154). It seemed as if the South African government was ready to deal with the HIV epidemic that was by now well-established in South Africa (Abdool Karim & Abdool Karim, 2005: 375, 376). Instead the South African Government's response to HIV that followed led to even more national and international criticism. The following describes the controversial decisions, policies, actions or inactions by members of the South African government.

Despite good intentions, NACOSA soon experienced difficulties. It did not get the power and resources it needed. Tensions between national, provincial, and local governments over budgetary allocations, programme design, and policy decisions hindered the successful implementation of the health plan. As a result the World Health Organisation's (WHO) global programme on AIDS intervened (Vliet, 2001: 161, 162). This created resentment in the post-apartheid government as the WHO was considered to be a non-consultative and Eurocentric organization (Squire, 2007: 40).

In 1995 media attention moved away from the troubled NACOSA to the state funded AIDS musical 'Sarafina II', a sequel to the popular musical 'Sarafina'. Only this time, instead of the storyline revolving around the student uprising during apartheid, it was centred around HIV prevention (Vliet, 2001: 162, 163). The idea of providing HIV prevention information through a popular musical was good; the actual implementation, however, has experienced criticism on several levels (Thornton, 2008: 164). First, the production was too expensive (Abdool Karim & Abdool Karim, 2005: 376). At a time in which funds were scarce the director billed the government 14 million South African Rand (ZAR) for the musical. Furthermore, the musical only reached a selected audience (Squire, 2007: 33), because during the writing no consultation took place between the government, civil society, and AIDS experts (Vliet, 2001: 162), the play was in English, the message was unclear, the fancy lights and sounds required the musical to take place at big professional venues, and the tickets were expensive (Thornton, 2008: 165). As a result the musical was cancelled after only a few shows and overall the production has been considered a waste of European funds donated to the government specifically for HIV prevention programmes (Thornton, 2008: 164).

The blunder of the 'Sarafina' musical was followed by the Virodene scandal. In 1997 a South African medical team claimed to have discovered that the drug Virodene could cure AIDS. Instead of following the ordinary ethical and scientific protocols, the medical team went straight to the cabinet to ask for financial support for further research. The South African government expressed interest in supporting Virodene research (Vliet, 2001: 163). However, there was no evidence of effectiveness which caused the Medicines Control Council (MCC) to refuse to allow the continuation of clinical trials (Thornton, 2008: 166). In the meantime HIV positive people were pleading to gain access to the drug (Vliet, 2001: 163, 164). Going against the advice from the MCC, the government led by President Mbeki awarded the company 3.7 million ZAR for further research (Thornton, 2008: 166). In the end Virodene proved to be toxic and to have no effect on HIV (Squire, 2007: 36). Several authors argue that Mbeki's unsubstantiated support for these researchers stems from Mbeki wanting desperately for it to be true. Besides curing AIDS, Virodene would have been an African solution. As such it would show the world that South Africa was not backwards, but instead the first country in the world to find a cure for AIDS. This would have supported Mbeki's vision of the African Renaissance, which is discussed in more detail below (Hyslop, 2006: 1; Thornton, 2008: 166) Furthermore, it would have restored the government's bad reputation after the 'Sarafina' blunder (Hyslop, 2006: 1-3).

Another controversy was the delay in making HIV treatment available to HIV positive pregnant women. Figure 2 presented at the start of this chapter, indicates the risk of an HIV positive mother infecting her baby. It also indicates how this risk can be reduced when treatment is used before and after giving birth. In 1998 clinical trials demonstrated that the drug Zidovudine (AZT) could reduce the risk of mother to child transmission (MTCT). Although these findings were initially welcomed in South Africa, rumours about AZT being poisonous delayed the actual implementation of AZT (Abdool Karim & Abdool Karim, 2005: 379; Squire, 2007: 37). After the Virodene saga, Mbeki was cautious not to push through medication that could in fact turn out to be poisonous. Instead he wanted to restore the government's image and therefore required further tests to be done to establish if AZT was indeed poisonous (Vliet, 2001: 169). There were also other reasons why Minister of Health Dlamini-Zuma did not roll out AZT. She stated that the focus of the government was on prevention and not on treatment, even though in this case treatment was used as prevention of MTCT. She also argued that the roll-out was too expensive, even though in the long run preventing HIV among infants would work out considerably cheaper than treating HIV

positive infants (Squire, 2007: 37; Vliet, 2001: 166, 167). Only after the Treatment Action Campaign (TAC) took the government to court in 2001, was it decided that the government had to rollout MTCT treatment (Squire, 2007: 39). In 2002 the government, led by Minister of Health Tshabalala-Msimang, gradually started the MTCT treatment rollout. By then they did not use AZT, but instead they used Nevirapine (Abdool Karim & Abdool Karim, 2005: 380; H. Phillips, 2012: 128; Thornton, 2008: 180). It took until 2004 before there were sufficient facilities implementing MTCT treatment (Abdool Karim & Abdool Karim, 2005: 380). Hence the intervention did not become available until the government was summoned to make it available and even then it took three more years before it was widely implemented.

Figure 8: Cartoon expressing criticism on the reluctant roll out of MTCT treatment. The doctor pictured is Minister of Health Tshabalala-Msimang
(Zapiro, 2002)

A further point of criticism has focused on President Mandela's silence regarding the topic of HIV and AIDS during his presidency (Abdool Karim & Abdool Karim, 2005: 376; Vliet, 2001: 165). Mandela had great authority and charisma, so it has been argued that had he addressed the issue more openly, it would potentially have made the topic less taboo. His silence on the topic suggested that HIV was not important enough to talk or worry about. However, it was difficult for Mandela to speak about HIV due to its immediate link to sexuality. Vliet has argued that for a man of his age and his position to speak about sexuality went against the sexual conservatism of South Africans (Abdool Karim & Abdool Karim, 2005: 376; Vliet, 2001: 165). When, after many years, he finally spoke about AIDS, he made it clear that because AIDS spreads mainly through sex, South Africans are forced to talk about things for which their 'traditions', cultures and religions have not yet provided them

with guidelines (Vliet, 2001: 165). Years after his presidency, Mandela admitted that he could have done more for HIV prevention (Abdool Karim & Abdool Karim, 2005: 376).

If President Mandela's evasive approach regarding HIV and AIDS led to criticism, this criticism proved to be mild compared to what his successor President Mbeki would endure. As briefly mentioned before, President Mbeki's main ideology during his presidency was based on the idea of an "African Renaissance". He envisioned the rebirth of a nation based on African pride, African cultural ambition, African sovereignty, and African self-reliance. He wrote the speech "I am an African" (Beinart, 2001: 304) in which he used South African history to construct an imagined community and to create solidarity and a shared South African identity.[4] Although Mbeki described South Africa's past as dark, oppressive and morally tainted, he also mentioned how in 1994 the new South Africa surprised the world with its strength to peacefully abolish apartheid. His reason for mentioning this recent part of the South African history was to create a sense of pride in what the country had achieved. According to Mbeki the African Renaissance was needed to overthrow the burden of the colonial stereotype (Mbeki, 1996). HIV worked both for and against Mbeki's vision of an African Renaissance. If South Africa could find a cure for AIDS it would stop the Western world from perceiving Africans as backward people who needed to be pitied and supported by the West (Posel, 2005: 146-148). This explains Mbeki's unsubstantiated support for the South African scientists who claimed to have found the cure for AIDS (Thornton, 2008: 181). However, HIV's main mode of transmission being sexual, threatened Mbeki's African

[4] 'I owe my being to the Khoi and the San whose desolate souls haunt the great expanses of the beautiful Cape - they who fell victim to the most merciless genocide our native land has ever seen, they who were the first to lose their lives in the struggle to defend our freedom and independence and they who, as a people, perished in the result. Today, as a country, we keep an audible silence about these ancestors of the generations that live, fearful to admit the horror of a former deed, seeking to obliterate from our memories a cruel occurrence which, in its remembering, should teach us not and never to be inhuman again. I am formed of the migrants who left Europe to find a new home on our native land. Whatever their own actions, they remain still, part of me. In my veins courses the blood of the Malay slaves who came from the East. Their proud dignity informs my bearing, their culture a part of my essence. The stripes they bore on their bodies from the lash of the slave master are a reminder embossed on my consciousness of what should not be done. I am the grandchild of the warrior men and women that Hintsa and Sekhukhune led, the patriots that Cetshwayo and Mphephu took to battle, the soldiers Moshoeshoe and Ngungunyane taught never to dishonour the cause of freedom. I am the grandchild who lays fresh flowers on the Boer graves at St Helena and the Bahamas, who sees in the mind's eye and suffers the suffering of a simple peasant folk, death, concentration camps, destroyed homesteads, a dream in ruins. (…) Being part of all these people, and in the knowledge that none dare contest that assertion, I shall claim that **I am an African' (...)** 'Because of that, I am also able to state this fundamental truth that I am born of a people who are heroes and heroines. (…) Patient because history is on their side, these masses do not despair because today the weather is bad. Nor do they turn triumphalist when, tomorrow, the sun shines. (…) It is a firm assertion made by ourselves that South Africa belongs to all who live in it, Black and White. (…) Today it feels good to be an African. (…) **I am an African' (Mbeki 1996).**

Renaissance ideology. Instead of linking sex to new life, at times of HIV sex was more likely to be linked to death. Posel described it as follows: "if sex produces death, then the infant nation is stillborn" (Posel, 2005: 148). Whereas Mbeki aimed to overcome colonial stereotypes, AIDS threatened to reinstate the racist stereotypes mentioned at the beginning of this section.

To minimize the negative impact of AIDS on the African Renaissance, Mbeki desperately tried to keep the discussion on AIDS away from racist suggestions about African sexuality by emphasising instead the link to poverty as an explanation for the high HIV prevalence in Africa. However, Mbeki's emphasis on poverty has been misunderstood by the media, who have portrayed Mbeki as an AIDS denialist. These accusations were further exacerbated when Mbeki set up an international AIDS advisory panel consisting of 16 AIDS denialists and 16 orthodox scientists (Abdool Karim & Abdool Karim, 2005: 378). His decision to keep an open mind towards unorthodox information about HIV caused the media to state that Mbeki claimed that HIV does not cause AIDS. Although Mbeki had the best intentions for his country, when he was misrepresented in the media he failed to clarify himself; instead he avoided the discussion altogether. This led to considerable confusion among the South African population. Eventually Mbeki was pressured to pull out of the discussion on AIDS altogether; in October 2000 Mbeki informed the ANC national executive committee that he was withdrawing from the public debate on HIV/AIDS (Vliet, 2001: 171, 176, 179). The government was also forced to make an official statement in which they acknowledged that "HIV causes AIDS" in an attempt to end the confusion (Abdool Karim & Abdool Karim, 2005: 379).

Mbeki was not the only person who required the government to release an official statement to clear things up. Minister of Health Tshabalala-Msimang was dubbed 'Doctor Beetroot' by her critics, because she promoted a juice (consisting of garlic, ginger, olive oil, lemon juice, beetroot and vitamins) over taking ARVs. People who are known to have followed her advice and stopped their ARV treatment briefly thrived on the juice, but soon after got worse and died. To fight the confusion that Minister Tshabalala-Msimang had created, the Deputy Health Minister who stood in for her when Tshabalala-Msimang herself became ill, was forced to officially state that although nutrition is important, it cannot replace ARVs (Squire, 2007: 44; Thornton, 2008: 173).

The final HIV scandal involving members of the South African government took place in 2006, when Zuma (Deputy President at the time) was in court on rape charges. Here he spoke

of the sexual intercourse he had had with the woman who accused him of rape. Although he was aware that she was an HIV positive AIDS activist, he did not use a condom. When asked about this, Zuma, who had been a member of the Presidential AIDS Commission, stated that what he had done was safe because he had taken a shower immediately after the intercourse. After the trial he commented that he had judged the chances of infection to be sufficiently low to be worth taking a risk (Hunter, 2010: 1, 2; Squire, 2007: 45; Thornton, 2008: 199, 200, 201). With these words Zuma contributed his share to the confusing statements about HIV and AIDS expressed by members of the South African government.

The statements of Mbeki, Tshabalala-Msimang and Zuma were detrimental to HIV prevention. For more than twenty years South Africa lacked clear leadership on HIV prevention. Instead of clear guidance there was foot dragging, ambivalence, disunity and confusion (Abdool Karim & Abdool Karim, 2005: 380; H. Phillips, 2012: 121, 125; Squire, 2007: 45; Thornton, 2008: 202). The government failed to warn, teach and support its citizens to reduce the spread of HIV, all of which gave the impression that the government did not take HIV seriously and if the government did not worry, then why would individuals worry. The misinformation, uncertainties and myths that still circulate today allow behaviour that places people at increased risk of HIV infection. This could have been greatly reduced had the South African government showed clear leadership and clear messaging on HIV prevention. Furthermore, the delay in making ARVs available has been described as criminal; although the government was not killing people, they were "letting them die" (Campbell, 2003; Thornton, 2008: 183). According to Cameron (2000) the government "has at almost every conceivable turn mismanaged the epidemic. So grievous has governmental ineptitude been that South Africa has since 1998 had the fastest-growing HIV epidemic in the world".

The foregoing discussion has highlighted all the matters for which the South African government has been heavily criticised in the years between 1987 and 2006, but this does not mean that during these years no positive contributions were made to HIV prevention. In 1999 Graça Machel, Nelson Mandela's wife, openly stated that her brother in law had died of AIDS. Then in 2004 Buthelezi, leader of the IFP, disclosed that his son died of AIDS. He was followed by Mandela, who in 2005 made the same statement about his own son (Squire, 2007: 43). Openly discussing the cause of death when someone died of AIDS was uncommon, therefore this was considered an important step towards reducing the stigma attached to HIV and AIDS. Furthermore, the Department of Health was supporting various AIDS campaigns that heightened HIV awareness and promoted behaviour change. In 2001

the government spent more than 1 billion ZAR on the 'comprehensive campaign' (Tshabalala-Msimang, Ngubane, & Pahad, 2001). The government also supported the '*Khomanani* campaign'[5] with 250 million ZAR. Three years later the government endorsed the 'ABC campaign', which promoted abstinence, being faithful, and the use of condoms (Tshabalala-Msimang, 2004).

After Zuma's confusing statements regarding HIV during his court case in 2006, he showed surprisingly clear leadership on HIV prevention and AIDS when he became President. In 2010 he launched a new HIV prevention and treatment plan. This plan did not solely focus on the promotion of condom use; instead the plan included the promotion of HIV counselling and testing, an increase in the ARV roll-out at a higher CD4 count, and the promotion of medical male circumcision. As part of the campaign Zuma underwent a public HIV test and he also spoke openly about having been circumcised. After years of confusing messages by members of the government, Zuma ultimately showed clear leadership and led by example (Zuma, 2010b). This new approach is discussed in detail in chapter 8.

1.4.2 Migrant labour system

A second factor contributing to the high HIV prevalence in South Africa is the elaborate migrant labour system, which has led to family fragmentation and high risk sexual behaviour among both men and women, allowing an easier spread of HIV (Jochelson, 2001: 171; Maharaj, 2001: 249). Chapter five discusses the historical events that led Zulu families to become reliant on the migrant labour system. The late 19th century saw the first surge in migrant labour, specifically in the mining industry. Due to an increase in mine wages and high levels of unemployment in other sectors there was another major surge in migrant labour in the late 1970's and into the 1980's (W. G. James, 1992: 56, 58, 65, 67). The peak of the migrant labour system was in 1985 when 1,833,636 South Africans were classed as 'migrants' (Abdool Karim & Abdool Karim, 2005: 163).

Living conditions at the mines facilitated risky behaviour. The migrants were housed in large, single-sex compounds, whilst their families had to remain behind in the rural areas (Beinart, 2001: 30). Being removed from family for long periods of time disturbed family stability. Furthermore, being removed from the community resulted in low levels of social cohesion. Consequently, at the mines men experienced anonymity, which broke down

[5] Khomanani means caring together and has been the government's HIV and AIDS communication brand.

systems of controlled sexual socialisation and led to an unprecedented sexual freedom (Abdool Karim & Abdool Karim, 2005: 302; Barnett & Whiteside, 2006: 119, 163; Kark, 2003 [1949]: 186; Marks, 2002: 19; H. Phillips, 2004: 32; Squire, 2007: 31). The mines also attracted workers from outside South Africa, for instance from Malawi, Mozambique and Botswana. It is believed that these foreign workers brought HIV to South Africa's mining communities (Abdool Karim & Abdool Karim, 2005: 302; H. Phillips, 2004: 32). As a result the sexual freedom experienced by the migrant workers became a serious HIV concern. Migrants missing their family and the warmth of a woman, in certain cases resulted in promiscuity. Sometimes these were casual relationships, but more often they were semi-permanent relationships. In exchange for contributing financially to the woman's household, these women would offer the migrant workers homemade cooking, companionship and sex (Jochelson, 2001: 104; Kark, 2003 [1949]: 181; Squire, 2007: 29). Clearly not every migrant worker had 'city wives'. There were men who merely abstained during the time they were away from home. Others again chose to have relationships with men in their compound to avoid getting drunk, falling for local women and wasting money. The latter option was dubbed a 'mine marriage' and has been described in detail by Moodie (Jochelson, 2001: 107, 108; Moodie, Ndatshe, & Sibuyi, 1988).

Working in the mines was dangerous. In her study on mineworkers, Campbell (1997) has described how every time mineworkers went underground they were unsure if they would survive their day of work, due to the high risk of mine accidents such as rock fall. Another virtually inevitable element of their job was picking up TB (in the past referred to phthisis) (Campbell, 1997: 276).[6] These mineworkers received HIV/AIDS information via educational videotapes, pamphlets and posters and had access to free condoms (Campbell, 1997: 275). Nevertheless, Campbell reported that in the context of rock fall, the high likelihood of health problems, and the large consumption of alcohol, the majority of her participants did not put this HIV prevention information into practice; instead they knowingly risked HIV infection. "There are two things to being a man: going underground and going after women" (Campbell, 1997: 278). This is how Campbell put into perspective how the risk of HIV, an illness that might affect them years down the line, did not really have them worried (Campbell, 1997: 277; 2003). As a result HIV transmission at the mines was rife (Squire, 2007: 29).

[6] HIV and TB are regarded as syndemic: each worsening the suffering and outcomes of the other disease.

During their visits home, migrant workers brought HIV to their wives or girlfriends in the rural areas (Abdool Karim & Abdool Karim, 2005: 302; Barnett & Whiteside, 2006: 163-167). Early on during the migrant labour system men would be away from home for long periods of time. They sometimes only came home once every year and a half. However in the eighties and nineties this had changed and men were able to return home on a more regular basis. As a result multiple sexual partners became multiple *concurrent* sexual partners. This created dense sexual networks, which according to Hunter and Thornton allows HIV to spread more easily (Hunter, 2010: 26; Thornton, 2008: 34). The fact that migrant labour led to the transmission of Sexually Transmitted Diseases (STDs) around the mining population and in the rural areas should not have come as a surprise, as Kark already described in 1949 how syphilis spread through migrant labour in the same way (Kark, 2003 [1949]). However, HIV transmission did not stop there. The rural wives, of whom many had been infected by their migrant husbands, sometimes had multiple concurrent relationships themselves. Some women who were lonely and struggled to make ends meet, perhaps because their husbands did not send enough money home from the mines, found men in the rural areas for alternative support. With these men they also created semi-permanent relationships. These relationships caused the further spread of HIV in the rural areas (Abdool Karim & Abdool Karim, 2005: 298; Jochelson, 2001: 100, 171; E. Preston-Whyte, 1994: 244).

Migrant labour is a system that facilitates or even encourages sexual networks that have proven to be disastrous for the spread of STDs. In the 1940's this was syphilis and in the 1990's it was HIV. The fact that the number of migrant labourers peaked just when HIV made its arrival into South Africa must have contributed to the fast spread of HIV in South Africa (Mulwo, Tomaselli, & Dalrymple, 2009: 312).

1.4.3 Wealth disparity

Poverty increases an individual's risk of HIV infection. Whereas Mbeki was unsuccessful in getting this point across, many writers have been more successful in documenting the link between poverty and ill health.[7] Living in poverty can lead to a lack of food, safe drinking water, shelter, education, sanitation and can also lead to increased levels of stress. As a result individuals living in these circumstances are more prone to infectious disease, whilst often having less access to healthcare (Abdool Karim & Abdool Karim, 2005: 381). Stillwaggon

[7] Stillwaggon (2006), Susser and Stein (2004), Hunter (2010), Farmer (2003), Packard (1992), WHO (2013), Marks (2002), and Scheper-Hughes (1993)

has stated that in the first place poverty increases the risk of contracting HIV and on top of this it increases the risk of contracting opportunistic diseases when someone is already HIV positive (Stillwaggon, 2006: 7). Furthermore, if medical conditions, for instance STDs, go untreated, individuals are at a higher risk of HIV infection (Wasserheit, 1992).

Poverty does not only biologically increase an individual's chances of HIV infection, it also stimulates risk behaviour (Stillwaggon, 2006: 11). Farmer has documented detailed life stories of women living in poverty in Haiti. In his writing he emphasises the limited options these women have to make ends meet. In their search for financial security they often become dependent on sexual relationships with men (Farmer, 2003: 40, 78). In these relationships women provide sex and the men provide financial support. Hunter (2010) depicts a similar situation in KwaZulu-Natal among unemployed women. He describes the experiences of several women who have multiple boyfriends to make ends meet. In return for love and sex, the men provide these women with money, clothes, groceries, cell-phones, new hair styles, alcohol, etc. Hunter's reference to this behaviour as the 'materiality of everyday sex', symbolises how these intimate relationships have a material emphasis. He also refers to it as 'provider love', as the relationship is based on the mutual obligation to provide; the men provide material goods and the women provide sex. Although the sex in these relationships is transactional, Hunter points out that these relationships are not like that of a casual client and a prostitute, but that of a long-term boyfriend and a girlfriend (Hunter, 2010: 4, 5, 16, 141). Due to the dependency element of these relationships women often feel unable to insist on condom use (Farmer, 1999: 84; Squire, 2007: 28). This situation clearly increases the risk of HIV infection. This is why Schoepf has stated that AIDS has "transformed many women's survival strategies into death strategies" (as quoted in Farmer, 1999: 79). Susser and Stein quoted their female participants stating that having jobs would be the best prevention for HIV. Having a job would mean that they would no longer be financially dependent on men and therefore it would be easier for them to set the terms and insist on particular behaviour, like the use of condoms, in their relationships (Susser & Stein, 2004: 134-138).

It is not only women who resort to having multiple relationships as a result of financial strain. The previous section already discussed how men who had left their rural areas as migrant labourers in order to provide for their families got involved with 'city wives' while away. However, Hunter describes the situation of a group of men who have multiple sex partners as a result of unemployment (Hunter, 2010). As will be discussed in detail in chapter six of this thesis, in Zulu culture marriage is an elaborate and therefore highly expensive

process. The same chapter also explains how marriage has been an important symbol of successful manhood. Being unemployed or having only a small income largely restricts the ability of a person to get married. As a result young men have to find alternative ways to prove their manliness. One of these ways is to show their friends that they are liked by women and that they are able to convince these women to have sex with them. This has resulted in the trend of men having multiple sexual relationships (Hunter, 2010; Tadele & Kloos, 2013: 65). At times of HIV, this is risky behaviour. So, in a similar way to the women in Susser and Stein's study, the men in Hunter's study also explained and blamed the spread of HIV on unemployment (Hunter, 2010: 18).

Hence poverty is one of the factors that can increase an individual's vulnerability to HIV infection. Gender inequality is another factor that can increase an individual's vulnerability. This is an issue central to this thesis and will be discussed throughout subsequent chapters.

1.5 Explanations for why KwaZulu-Natal has a high HIV prevalence

Figure 7 also shows how KwaZulu-Natal stands out as the worst affected province within South Africa since the nineties. In my opinion it is a combination of the aforementioned national factors (i.e. confusing messages from the government, the migrant labour system, and wealth and gender disparity) and the following region-specific factors that have contributed to KwaZulu-Natal standing out as the province with the highest HIV prevalence in South Africa. These region-specific factors are: the widespread violence between opposing political factions in KwaZulu-Natal during 1987-1997, the fact that the country's busiest national transport route runs through the province, and the lack of male circumcision amongst the Zulu male population.

1.5.1 Post-apartheid political violence

In KwaZulu-Natal the years leading up to and immediately following the first democratic elections in South Africa (1987-1997) were marked by political violence between supporters of the ANC and the IFP. Especially the two areas central to this thesis (eThekwini and Umgungundlovu) experienced high levels of political violence (Jeffery, 2009). I argue that the preoccupation with this violence is one reason why HIV was able to spread relatively freely during the early years of the epidemic in KwaZulu-Natal.

In 1980 tension arose between supporters of the ANC and the IFP. Officially the ANC had been banned causing its supporters to come together under the UDF, which was founded in 1983 (Ashforth, 1991: 66, 67). Violent conflicts between UDF *amaqabase* (comrades) and

IFP '*impi'* (army) followed soon after the formation of the UDF. This happened predominantly in KwaZulu-Natal but also elsewhere. At first these conflicts only happened occasionally, but from 1987 the tension escalated into what has been referred to as 'the people's war' (Jeffery, 2009), 'the turmoil' (Vliet, 2001), 'the political violence' (Bonnin, 1997), 'the post-apartheid political violence' and 'the unofficial war' (Taylor, 2002).

On both sides the violence gradually escalated. It started with stoning buses and stealing food, household goods, clothing and cattle from the opposition, but gradually turned to destroying and burning down houses and injuring, kidnapping, or even executing the occupants (Bonnin, 1997: 64, 65; L. Levine, 1999: 97, 105, 121; Ross, 1999: 179). The killings were brutal. Some people got shot in the back while trying to run away. Others were killed by 'necklacing' (in which a petrol-filled tire was forced over a person's chest and set alight). There were people who were decapitated and others were victims of stabbing overkills (Jeffery, 2009: 184). Understandably, people lived in fear of these attacks. Too scared to stay at home during the night, many families slept out in the bush or in the hills, or they fled the area altogether (Bonnin, 1997: 67). According to some sources the violence amounted to a civil war in KwaZulu-Natal, which resulted in 60,000 refugees (Jeffery, 2009: 184) and the loss of 20,000 lives (Taylor, 2002: 473).

The youth were forced to choose a political side. They had to join either the *impi* (IFP) or the comrades (ANC/UDF). It happened regularly that young men would be approached at school, and if they did not support the right political party they risked being kidnapped, injured or even killed (Bonnin, 2000: 307). There are also known cases in which, whilst making their way to or from school, young women were approached by both *impi* and comrades who demanded that these young women proved their political loyalty by having sex with them. Aware that resistance could put their families in danger or could result in rape, these women had little choice but to comply (Bonnin, 2000: 307-309; Leclerc-Madlala, 1997: 370; Marks, 2002: 20). Aside from this being a traumatic experience, the rape or the casual sex demanded by the *impi* and the comrades also drove the spread of HIV. As a result of the violence youth stopped attending schools and many schools closed down for extended periods of time. In the past members of both parties had shared shops, churches and neighbourhoods. Over time, as the violence grew stronger, many people chose to move or fled to areas known to support their political party. Many refugees were living in churches, community halls and school buildings. Living in these designated areas allowed the residents to move somewhat safely within their area, while shops and churches outside their area were out of bounds.

People who had to travel through opposition territory on their way to work, struggled to hold on to their jobs (Bonnin, 1997: 65-67; 2000: 307).

As a result of this constant threat of violence, life in the period between 1987 and 1997 was far from ordinary. Whilst the people in KwaZulu-Natal focused on surviving the political violence, the spread of HIV almost went unnoticed (Bonnin, 2000: 310; Leclerc-Madlala, 1997: 363). With institutions like schools being disrupted or even closed for long periods of time, a formal platform to educate the youth about HIV prevention was missing. Furthermore, in response to the displacement and the extreme violence people had witnessed, it was common for people to suffer from post-traumatic stress. They lacked self-efficacy and as a result they were unable to make plans for the future, including considering HIV prevention (Bonnin, 1997: 66; Campbell, 1997: 277). The youth growing up during this time have been referred to as the 'lost generation' (Leclerc-Madlala, 1997: 376). The violence and the lack of control had also led to both a fatalistic and an invincible attitude. Several young men regarded becoming HIV positive as an inevitable condition of being sexually active: they believed they were going to become infected with HIV sooner or later. Others believed they had survived all the violence because they were invincible (Leclerc-Madlala, 1997: 366-368) and would thus not be at risk of infection. Altogether this created unlikely conditions for the implementation of HIV prevention behaviour and therefore contributed to spread of HIV (Vliet, 2001: 159).

1.5.2 Location along the busiest national trucking route

Besides this extended period of severe violence, another element characteristic of KwaZulu-Natal is that it hosts the busiest trucking route in South Africa; the N3, the national route that links Johannesburg and Durban. Via this route trucks move between Johannesburg, the industrial and mining capital of South Africa, and the port of Durban, which is the busiest port in South Africa as well as the busiest container port in the Southern hemisphere (Ulwazi, 2014a).

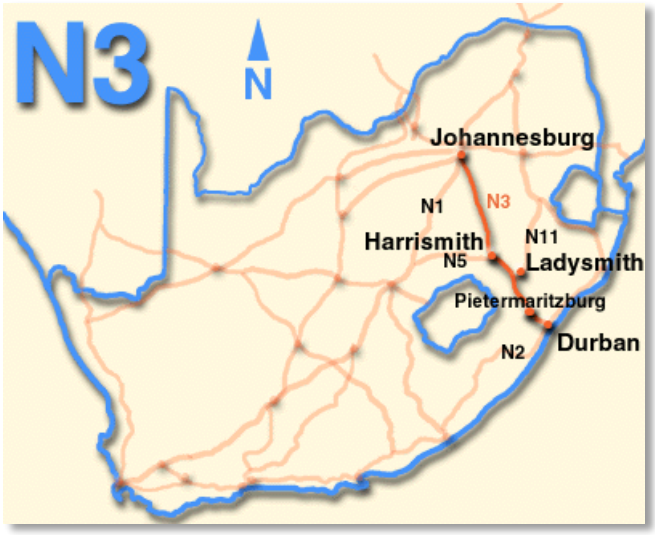

Figure 9: Map of South Africa showing the national routes and highlighting the N3 (Mike, 2014)

Several studies have noted that, similar to the mines, truck stops are epicentres for HIV transmission and they have referred to truck drivers and sex workers as 'core transmitter groups' (Abdool Karim & Abdool Karim, 2005; Iliffe, 2006; Marcus, 2001; R. Parker, Easton, & Klein, 2000; Squire, 2007). Long haul truckers work long hours, they are away from home for long periods of time, they are likely to experience feelings of isolation and loneliness, and they only have limited opportunities for recreation. This often results in truck drivers seeking companionship and sex at the truck stops. Although the truck drivers are aware of the risk of HIV, the majority of them do not consistently use condoms (Marcus, 2001: 110, 115, 116). In 1996 the South African Medical Research Council undertook research on sex workers and truck drivers at truck stops along the N3. They found an HIV prevalence of 56% among the truck drivers. These truck drivers travelled through at least three provinces in South Africa and more than half of them also travelled to neighbouring countries (Abdool Karim & Abdool Karim, 2005: 289, 293). Those of them who had unprotected sex throughout these journeys have contributed to the high HIV prevalence in KwaZulu-Natal (Squire, 2007: 30).

1.5.3 Absence of male circumcision

A final characteristic of KwaZulu-Natal, which I argue has contributed to the high HIV prevalence, is the fact that at the time that HIV arrived in South Africa the majority of Zulu men were not practicing male circumcision. According to the WHO medical "male circumcision reduces the risk of heterosexually acquired HIV infection in men by

approximately 60%" (WHO, 2012a). Chapter eight discusses in detail the Zulu history of male circumcision. For now it is sufficient to state that over the past 200 years male circumcision has generally not been practiced by Zulu men, whereas the neighbouring Xhosa men, for example, did practice male circumcision (Squire, 2007: 29). I argue that this is another factor that has contributed to KwaZulu-Natal standing out as having the highest HIV prevalence.

1.6 Thesis overview

This introduction has provided the necessary political, historical, economical, social, and geographical background information to understand in what context HIV has been able to spread through South Africa and more particularly KwaZulu-Natal. It is valuable to have an understanding of this background information before focusing on the relationship between Zulu culture and HIV prevention throughout the rest of the thesis. The main research question is: How do community HIV educators in KwaZulu-Natal negotiate HIV prevention in their everyday intimate relationships? This question will be broken up into sub-questions that will be addressed in the subsequent chapters.

An important element as part of the main research question is the individual's ability to act. Therefore the conceptual framework set up in chapter two revolves around the question: what motivates an individual's practice? Is it determined by individual choice or by structural factors? This chapter draws on practice theorists Bourdieu and Archer to argue that practice is motivated by a combination of structure and agency.

Whereas chapter two discusses practice in general, chapter three looks at health practice and in particular the implementation of HIV prevention. The health promotion field has traditionally been dominated by psychologists who have focused their work on individuals. Consequently, initial HIV prevention interventions have focused on providing individual HIV awareness. However, as chapter two argues, individuals act as part of collectivities and more recently HIV prevention campaigns have started to move away from merely addressing the individual and instead have started to address the collective in order to create behaviour change. Besides the literature review, this chapter also introduces two Non Governmental Organisations (NGOs) that have formed the basis for this study. Both NGOs have identified that individual HIV awareness by itself is often not sufficient to lead to behaviour change and have identified gender inequality as the biggest obstacle to the implementation of HIV prevention.

Chapter four, the methodology chapter, provides a description of the rural area and the Zulu family where the author based herself during the research. Furthermore, it gives an insight into the different data collection techniques used throughout the research. It then describes how this data was analysed. Chapter four finishes with a reflexivity section, which critically analyses how the personal characteristics of the researcher have impacted what data was gathered and how this was interpreted.

Both chapter five and six provide necessary cultural background information. Chapter five is an historical overview of the sexual socialisation of Zulu youth between 1816 and 2011. By going from strictly controlled and closely guided puberty rituals during the time of Shaka and Mpande's rule, to a taboo on sexuality and the breakdown of social control during colonialism, this historical overview offers an insight into the current sensitivity of talking about sexuality. This is of great importance to this thesis, as talking about sexuality is an indispensable part of HIV awareness and implementing HIV prevention. Chapter five also sets up the discussion around the concepts of 'tradition' and 'modernity', which will be referred back to in chapter eight. It demonstrates the flexibility of these concepts by first showing how 'tradition', despite being pictured as static, adapts over time to remain relevant in a changing reality, and second by showing how 'modern' elements at times are appropriated as 'traditional'. Finally this chapter also presents examples of 'discreet indiscretions', a concept first referred to in chapter two. Discreet indiscretion is the respectful execution of what is generally considered to be inappropriate behaviour by making sure it takes place out of sight and remains unnoticed. It is a method that enables individuals to deviate from the social norm in a respectful manner.

Chapter six provides an overview of both the historical and the contemporary practices around the initiation of sexual relationships. This chapter sheds light on gender relations by focusing on the communication and negotiation that takes place between men and women, first during courting and later within marriage. This is an important element of this thesis, as it is within this setting that individuals are expected to negotiate and implement HIV prevention. This chapter follows on from the previous one by presenting more examples of 'discreet indiscretions', by which individuals can achieve the 'second-best outcome' whilst being restricted by structural factors.

Having described the context in which romantic couples can and cannot talk about sexuality in chapter five and six, chapter seven links this to HIV prevention by focusing on condom use as a strategy to prevent HIV transmission. The chapter makes use of a discourse

analysis on condom use to identify the difference between when community HIV educators speak in support of condom use, when they speak against the use of condoms, or when they avoid the topic altogether. It then goes on to explain how this affects the ability of the community HIV educators to implement their HIV prevention knowledge in their everyday intimate relationships. It describes how several participants find it difficult to implement condom use. The explanation of what causes them to experience this as difficult highlights the restrictions of structural factors on the individual practice of the community HIV educators.

Whereas chapter seven gives examples of structural factors obstructing HIV prevention when it comes to condom use, chapter eight shows how structural factors can also have a facilitating effect on HIV prevention strategies when it comes to alternative HIV prevention strategies such as medical male circumcision and virginity testing. At the same time, the chapter demonstrates that individual practice is not determined by structural factors. Agency is highlighted when the chapter discusses how several community HIV educators who struggle to negotiate condom use, opt for negotiating HIV testing with their sexual partners instead. Hence, this chapter describes three alternative HIV prevention strategies. Compared to condom use, these alternative strategies provide less protection against HIV transmission. Yet they seem to be more popular amongst the participants of this study. To explain the popularity of these alternative strategies, chapter eight reflects on the discussion on ‘tradition’ and ‘modernity’ started in chapter five.

Chapter 2: Conceptual framework

2.1 Introduction

This thesis analyses the willingness and ability of community HIV educators to introduce HIV preventative practices into their everyday intimate relationships. The fact that these individuals have been subjected to extensive HIV prevention campaigns is what makes studying their particular behaviour so significant. In South Africa HIV interventions designed in the first twenty years of the epidemic generally followed the ideology of the social cognition models. These models are discussed in detail in chapter three, but in short, social cognition models focus on individual behaviour change. As a result, HIV interventions in South Africa focused on individual HIV awareness. Despite good intentions, this effort did not lead to the expected individual behaviour change on a large scale. To convince policy makers of the importance of moving beyond individual awareness it is informative to study what the community HIV educators, who have been at the receiving end of individual HIV awareness campaigns, identify as enabling and limiting factors in implementing HIV preventative behaviour.

By turning to Bourdieu's concept of habitus, field and capital, this chapter attempts to explain why individual HIV awareness campaigns struggled to lead to individual behaviour change. Bourdieu argues that even though it is an individual that acts, what the individual chooses to do is heavily influenced by structure. Using the concepts habitus, field, and capital, Bourdieu explains how structural factors influence individual behaviour (Bourdieu, 1977) and this can be applied fruitfully to the question of HIV prevention behaviour.

Bourdieu himself has not linked his theory to health practice, but Cockerham (2007) and Korp (2010) have used Bourdieu's theory to explain that health-related behaviour cannot be reduced to individual-level attitudes and behaviour. Cockerham critically remarks that the individual-focused models used in health promotion perceive the individual "as an autonomous actor making self-governing decisions in a social vacuum" (Cockerham, 2007: 54). Both Cockerham and Korp perceive this individual focus as unacceptably reductive, because "the consciousness and intentionality of the individual is always related to the particular individual's conditions of existence and position in the social structure", hence the individual focus ignores the complexity and the situatedness of social action (Korp, 2010: 800, 805). People might be well aware of their personal risk, but unable to change it. Cockerham describes an example given by Williams whose respondents:

> understood the behavioural risk factors that made ill-health more likely and for which they were in a limited sense, responsible, but they were also aware that the risks they faced were part of social conditions that they could do little to change (Cockerham, 2007: 54).[8]

Although this thesis stresses the impact of structural factors on individual practice, it also leaves room for agency. It attends to alternative strategies; individuals making the best of their situation and attempting to prevent HIV infection to the best of their ability. To support this argument the thesis draws on the work of Archer and her ideas of well-considered 'projects' and 'second-best outcome'.

2.2 Individualism, structuralism or a combination of both?

It is important to begin by asking the more general, but central, question in social science: What motivates an individual's practice? There are individualists who argue that practice should be understood in terms of individual motives and interests (Eriksen, 2001; Ritzer & Goodman, 2004b; Swartz, 1997). "What actors do, it is assumed, is rationally go after what they want, and what they want is what is materially and politically useful for them within the context of their cultural and historical situations" (Ortner, 1984: 151). They suggest that individuals are in control of their conscious and intentional actions. According to this theory individual choice takes primacy over any form of external structural forces (Korp, 2010: 804).

There are also structuralists, who argue that "human action and historical process are almost entirely structurally or systematically determined. Whether it be the hidden hand of structure or the juggernaut of capitalism that is seen as the agent of society/history" (as quoted in Ortner, 1984: 144). According to this theory external structural forces take primacy over individual choice (Korp, 2010: 804).

In the seventies practice theorists joined the discussion by looking at the relationship between structure and agency. Examples of practice theorists are Bourdieu, Giddens, de Certeau, Sahlins, and Archer (Morris, 2002: 38; Ortner, 1984: 144; Ritzer & Goodman, 2004a: 69, 70). Practice theorists are of the opinion that structuralism ignores the fact that individuals have choices, whilst individualism ignores the objective social and mental

[8] With situations like these in mind, Ogden argues for the importance of speaking of 'vulnerability' instead of 'individual risk'. "Vulnerability is a sociological concept that refers to the extent to which the risk of transmission is affected by factors in the broader social and/or physical environment, which may be beyond the control of any or all individuals involved" (Ogden, Gupta, Fisherc, & Warnerd, 2011).

realities that can limit an individual's choices (Ritzer & Goodman, 2004a: 70). In response practice theorists consider individualism and structuralism as complementary. They argue that practice is motivated by a combination of structure *and* agency.

In this thesis I have chosen to work only with Bourdieu and Archer's interpretation of practice theory because Bourdieu's interpretation has extensively influenced the field of social science and in combination with Archer's interpretation their theory seems most relevant to my study. According to Bourdieu, practice is not a "mechanical reaction" (Bourdieu, 1977: 73), yet practice is not a "deliberate pursuit of a conscious intention, the free project of a conscience positing its own ends and maximizing its utility through rational computation" either (Bourdieu & Wacquant, 1992: 121). Hence practice "is not determined by structure, neither do people have free will"; instead practice is "the product of practical knowledge" (Morris, 2002: 21, 22). Bourdieu refers to Leibniz, when he argues that 75% of practice is motivated by practical sense and only 25% by rationality (Bourdieu & Wacquant, 1992: 131). Practical sense is "prereflective" (Swartz, 1997: 101). It takes place below the level of calculation, consciousness, discourse and representation. Although practice theorists still acknowledge the powerful and at times determining effect of structural factors on individual practice, they mainly seek to explain how structural factors influence individual practice (Ortner, 1984: 146, 148). Practice motivated by practical sense follows a "sense of the game" (Bourdieu & Wacquant, 1992, 128). Instead of the individual giving it a great deal of thought, the individual follows intuitively what one in their position is disposed to do (Cockerham, 2007). External structures are internalised by an individual through dispositions and practice follows on from these dispositions or what Bourdieu terms habitus (Morris, 2002: 22).

This thesis attempts to explain why, when it comes to individual implementation of HIV prevention behaviour, collective efforts have better results than individual HIV awareness campaigns. Bourdieu's concept of habitus, field and capital are helpful tools in this explanation. Chapters five and six describe in detail how external structures around sexual education, courting and gender relations are internalised by individuals. Chapter seven describes how these external factors hinder individuals from implementing condom use, whilst chapter eight describes how these structural factors enable individuals to implement alternative 'traditional' HIV prevention interventions.

2.2.1 Habitus

Bourdieu's concept of habitus focuses on the interplay between structure and agency (Korp, 2010: 804). He defines habitus as:

> Systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles of the generation and structuring of the practices and representations which can be objectively "regulated" and "regular" without in any way being the product of obedience to rules, objectively adapted to the goals without presupposing a conscious aiming at ends or an express mastery of the operations necessary to attain them and, being all this, collectively orchestrated without being the product of the orchestrating action of a conductor (Bourdieu, 1977: 72).

It is a detailed definition which, in an attempt to make it easier to process, has been summarised by many scholars. Cockerham for example, summarises Bourdieu's definition of habitus as follows:

> Habitus serves as a cognitive map or set of perceptions in the mind that routinely guides and evaluates a person's choices and options. It provides enduring dispositions toward acting deemed appropriate by a person in particular social situations and settings (2007: 70).

Bourdieu himself has summarized habitus as a "durable installed generative principle of regulated improvisations" (Bourdieu, 1977: 78). The shortest description of habitus I have come across is given by Holton, who speaks of "common sense" (as quoted in Ritzer & Goodman, 2004b: 520), which indicates the complexity of what once may have seemed like a straightforward concept. Dispositions become second nature and incline the practice of individuals. It is the individual that acts, but what the individual chooses to do is heavily influenced by structural factors. As such habitus can be compared to grammar, the way in which grammar organises speech, habitus organises practice (Swartz, 1997: 102).

Chapter six, for example, describes the standard interaction when a man courts a woman. The script I have been able to record is an example of habitus, or "conductorless orchestration"; it is "objectively harmonized without any intentional calculation or conscious reference to a norm" (Bourdieu, 1977: 80). Although these are individual projects, it is

habitus that inclines the behaviour of the individuals involved. As a result of watching the behaviour of their older siblings, men and women have come to embody the rules about how a man proposes and a woman declines.

2.2.2 Field

After his initial focus on habitus, Bourdieu later introduces the concept of field, which connects habitus to power (Swartz, 1997: 9). Crossley explains that fields are sites of practice, where networks of interdependency, competition and power are at play (Crossley, 1999: 649). It is like a playing field (Korp, 2010: 805), a structured arena for power struggles (Swartz, 1997: 9). Bourdieu defines field as: "a network, or a configuration, of objective relations between positions" (Bourdieu & Wacquant, 1992: 97). A field is a social space made up of positions. "To think in terms of field is to think relationally" (Swartz, 1997: 119). Interaction between individuals in the field is determined by their positions in relation to each other. Positions are not equal, instead they are hierarchically arranged, which means that there are dominant and subordinate positions (Swartz, 1997: 120, 124). The position an individual takes in the field is determined by the amount of capital he possesses and subsequently where he is positioned in the field influences his subjectivity (Morris, 2002: 24).

Upon birth an individual is immediately appointed a particular position in the existing social system, depending on, for instance, the class or status group of the infant's parents (Morris, 2002: 23). Within this particular position the individual acquires a fitting habitus. This habitus guides the individual within the broad parameters and boundaries of what is and what is not possible, likely, accessible, and reasonable for a person in their position. Habitus sets structural limits for practice as habitus is internalised and then transformed into individual aspirations and expectations (Swartz, 1997: 103). Hence it teaches a child his or her place in society (Bourdieu, 1977: 77).

Once an individual has internalized his or her place in society, the individual is likely to remain in that place (Swartz, 1997: 106). The individual will perceive the practice that he or she grew up with as "natural" and therefore deviant practice might be perceived as "unthinkable" or "scandalous" (Bourdieu, 1977: 78). This way habitus works as a self-fulfilling prophecy, it reproduces itself (Swartz, 1997: 103). In case the individual does act out of place his family and peers are likely to put him straight by saying things like: you are 'too big for your boots', your are 'full of airs and graces', 'know your place' (Skeggs, 1997: 11), and "that is not for the likes of us" (Bourdieu, 1977: 77).

Bourdieu's idea of position in the field resembles Foucault's discussion of subject position. Discourses create discursive locations which come with a certain power that strongly influences the relationship among people and subject positions also have direct implications for subjectivity (Miles, 1992: 14).

Chapter seven attends to a difference observed in the discourse of the participants when it comes to talking about condom use. To analyse these different discourses a distinction is made between three different fields. The professional field in which the participants interact as community HIV educators with their clients. The public field in which the participants interact as peers with their friends. And the domestic field in which the participants interact as family members with their parents, siblings, or children. Chapter seven shows how references made to condoms considered appropriate in the one field are scandalous in another field and how this ultimately influences an individual's ability to discuss the use of condoms with a sexual partner.

2.2.3 Capital

Besides habitus and field another concept used by Bourdieu is capital. He uses this economic metaphor to analyse "how access, resources and legitimation contribute to class formation" (Skeggs, 1997: 9) and why for some people it is easier to implement certain practice than it is for others. As mentioned earlier, the particular position of an individual in the field is determined by the amount and kind of capital that individual possesses compared to others in that same field. Capital refers to resources and functions as a "social relation of power" (Swartz, 1997: 122). Bourdieu discusses four types of capital: economic, cultural, social and symbolic capital (Bourdieu, 1986).

Economic capital "is immediately and directly convertible into money" (Bourdieu, 1986: 243). Examples of economic capital are income, labour, inheritance, and assets like property, land, and cattle.

Cultural capital can exist in three forms. First, it can exist in the embodied state, in the form of long lasting dispositions (Bourdieu, 1986: 243), for example general cultural awareness, style of speech and dress, gender roles, knowing how to be a good host, brew beer, keep a vegetable garden, etc. The second form in which cultural capital can exist is the objectified state, in the form of cultural goods (Bourdieu, 1986: 243), for example, pictures, books, dictionaries, instruments, machines, etc. The final form in which cultural capital can exist is the institutionalised state; (Bourdieu, 1986: 243) in the form of, for example, educational qualifications.

Social capital refers to being linked into a social network (Swartz, 1997: 74, 75), for example a community a family, a school, a sports club, a work environment, a religious congregation, and a trade union. These memberships come with social obligations, but also provide access to resources and come with social backing when needed (Bourdieu, 1986: 248, 249).

Symbolic capital involves an individual receiving honour and prestige from other people in the same field (Swartz, 1997: 74, 75). It starts with identifying what are considered highly valued properties in a particular field. For example, in my particular research site, the status of *umnumzana* (a married man and head of the household), the practice of *hlonipha* (expressing respect through avoidance), female virginity, and male virility (four topics that will be discussed in detail throughout this thesis) were highly valued. Individuals who could successfully claim that they possessed these properties accumulated symbolic capital and consequently received respect from people in their field (Morris, 2002: 26).

The idea of capital becomes relevant when trying to understand interactions, negotiations, and power relations. The relationship between men and women, more particularly gender inequality, is central to this thesis. Chapter six, in particular, takes a closer look at these power relationships when analysing the ability of the female participants to gain economic, cultural, social, and symbolic capital by working at 'Women and Children First'.

To conclude, Bourdieu argues that practice is the result of the interaction between habitus and field. Although habitus predisposes individuals to feel and act in certain ways, by itself it does not determine practice. Practice is the outcome of "habitus in relation to a particular power position occupied by a group within a field and the group's cultural capital" (McAllister, 2006: 47). Bourdieu summarises it in the following equation: "[(Habitus) (Capital)] + Field = Practice" (Swartz, 1997: 141).

2.2.4 Transferring capital between fields

Different fields require different skills and different forms of capital from their participants. For example an individual can be successful in the biomedical field, because this individual has been educated to become a doctor. This individual will have the habitus and the cultural, symbolic and social capital necessary to have a 'feel for the game' and therefore to be effective in the biomedical field (Crossley, 1999: 650, 666, 667). Part of the biomedical field is the relationship between the doctor, the expert who is likely to behave in a strong, dominant, and professional manner, and the patient, who is in a vulnerable position and is likely to behave in a passive and emotional manner.

However, the relationship between these two people is not fixed. A power shift is possible. It depends on the field of their interaction. The same doctor might have little experience and knowledge in the wild outdoors. When he finds himself in a canyon with the same patient, who happens to be a canyon guide, their positions reverse. This time it is the canyon guide that will have the 'feel for the game', the know-how. He is the expert who knows how to get both of them safely down the canyon. Suddenly the doctor is the layman and as they make their way down the canyon he relies on the expertise of the canyon guide. The same individuals interact, but their subject positions have reversed. This illustrates that subject positions are not static, but field dependent. In the past when social scientists spoke of identity, they portrayed a relatively fixed notion of the subject. However, an individual may shift from one discourse to another within one context, or in different contexts. This is why more recently post-structuralists and feminists chose to speak of subjectivity and subject position instead of identity. This allows for a fluid subjectivity in which subjects are always in the making, they are often contested, and in many cases they incorporate contradictory elements (Berg, 2009: 215; Kendall & Wickham, 1999: 54; Miles, 1992: 15).

The example above indicates how in the first field (the clinic) the doctor was in a dominant position over the canyon guide who was his patient, because the doctor possessed all the necessary capital to have a feel for the game. In the second field (the canyon) the positions reversed and it was the canyon guide who was in the dominant position. To show that it is not always this straight forward, I would like to introduce another element to this example; the possibility of capital gained in one field being transferred into another field (McAllister, 2006: 48). For the sake of the argument imagine that the doctor is one of three participants going on a canyoning trip with the canyon guide. Halfway through the canyon one of the clients (not the doctor) gets injured and needs medical assistance. When it comes to medical issues, the years of medical training and experience in the clinic easily trump the medical training of the canyon guide. So the doctor could transfer his cultural capital, i.e. his medical training, to attend to the injured participant. However, the setting is very different from what the doctor is used to. He does not have access to the clinic's equipment, he is faced with cold and wet circumstances in the canyon, and the situation requires a technical rescue to get the injured participant out of the canyon and to the hospital. For this reason his capital can only be partially transferred and the canyon guide is likely to remain in charge of the overall situation. The canyon guide's training and experience specified to dealing with situations in the outdoors might in this case be more valuable than the doctor's medical training. So

besides showing that capital can be transferred between fields, this example also shows how the particular field plays an important role in valuing somebody's capital and subject position. After chapter six has analysed how the female participants gain economic, cultural, social, and symbolic capital by working at 'Women and Children First', it will demonstrate how these participants are able to transfer this capital between the professional field (at the NGO) and the domestic field (when they are home). Whilst focusing on one particular example it shows how increasing levels of capital can enable participants to control their own fate (Ritzer & Goodman, 2004b: 523) and introduce changes in health behaviour. Hence it increases an individual's agency.

Among other things, chapter six attends to Nomsa's (one of the female community HIV educators) response to her cheating husband. Prior to working at the NGO Nomsa could not afford to express any criticism. All the capital she had accumulated was through her husband. He owned their house, he financially provided for their children, and he gave her the elevated symbolic status of a married woman in her community. This gradually changed when Nomsa started working. Chapter six describes the capital she accumulated from working at 'Women and Children First'. It also demonstrates how Nomsa was able to transfer the capital accumulated in the professional field to the domestic field and how this eventually enabled her to speak out to her husband, or in other words, how her increasing levels of capital increased her agency.

2.3 The location of agency

This last section comes back to the question posed at the start of this chapter: what motivates an individual's practice, is it determined by structural factors (such as social class position and gender), or individual choice (Cockerham, 2007: 55; Swartz, 1997: 8)? In other words: where is agency located?

2.3.1 Bourdieu

Bourdieu does not argue for the one or the other answer; instead he brings the two together. Although Bourdieu's theory of practice supports the mutual dependency of agency and structure and suggests that both are equally essential, this does not mean that he perceives agency and structure as equal. Overall, Bourdieu emphasises the influence of structure, over the influence of agency (Ritzer & Goodman, 2004b: 520). Bourdieu advocates for the acknowledgement that material, cultural and political structures can limit an individual's options (Cockerham, 2007: 53). As a result of this advocacy, Bourdieu has been criticised as

being too deterministic by some. For example, Jenkins argues that Bourdieu does not grant agency enough power. Jenkins goes as far as to suggest that, despite his criticism of objectivism and structuralism, ultimately Bourdieu is an objectivist himself (Ritzer & Goodman, 2004b: 520).

Fuchs (2008) rejects the criticism that Bourdieu is too deterministic. Although the individual practice of members of the same group or class will all be influenced by the same habitus, this does not mean that their thoughts, perceptions, expressions, and actions will all be the same. Habitus does not fully determine the practice and thoughts of group members. "The creative human being is not a pure object of social structures; he has relative freedom of action due to creativity and self-consciousness", hence habitus "neither results in unpredictable novelty nor in a simple mechanical reproduction of initial conditionings" (Fuchs, 2008: 56).

Fuchs is not the only one who has defended Bourdieu. Swartz (1997) says that although Bourdieu's emphasis lies on structure, in the concept of strategy he does allow room for agency. Bourdieu explains that habitus does not "determine" practice, it "merely suggests" practice (Ritzer & Goodman, 2004b: 521). "Social agents don't do just anything, (…) they are not foolish, (…) they do not act without reason" (Bourdieu, 1998: 75). "Behaviour, then, is strategic rather than rule or norm conforming" (Swartz, 1997: 99). Bourdieu brings in the concept of strategy to introduce agency into habitus and to argue that individuals do not simply follow structure. Actors are not rule followers but strategic improvisers who respond dispositionally to the opportunities and constraints offered by various situations (Swartz, 1997: 100). Bourdieu considers all action to be interest orientated. He quotes Weber: "Social individuals obey a rule only insofar as their interest in following it outweighs their interest in overlooking it" (Bourdieu & Wacquant, 1992: 115).

Hence "individuals do not passively absorb external determinations, but are actively engaged in the interpretation of experience and, therefore, in a process of self-formation, albeit on a pre-reflexive level" (McNay as quoted in Morris, 2002: 40). It is important to note that Bourdieu's understanding of strategy does not refer to "the purposive and preplanned pursuit of calculated goals" (Bourdieu & Wacquant, 1992: 25). Bourdieu believes practice "is not the result of an individual weighing the odds, consciously matching their aspirations to their real objective chances" (Morris, 2002: 22). Instead it refers to practical strategizing which stems from the dispositions of the habitus (Swartz, 1997: 114). Individuals respond dispositionally to opportunities and constraints. According to Bourdieu their practice is:

> the outcome of the dispositions durably inculcated by the possibilities and impossibilities, freedoms and necessities, opportunities and prohibitions inscribed in the objective conditions (...) [which] generate dispositions objectively compatible with these conditions and in a sense pre-adapted to their demands (as quoted in Morris, 2002: 22, 23).

Habitus has subconsciously limited the aspirations by excluding as unthinkable the most improbable practices from the outset. Morris (2002) explains this well by using some of her own material. She brings attention to a participant who ended up as a high country farmers' wife, just like her mother. Although the participant had not actively gone out to become a high country farmer's wife, she had turned into one. Morris explains that this reveals:

> the force of habitus, of the way in which inculcated dispositions predispose a person to strive towards the position they were objectively most likely to attain already by the virtue of their position within the field. (…) [The] goal was not the outcome of a deliberate strategy, nor of total determination by structure, but of a deep interest in the game (Morris, 2002: 380).

Ultimately, according to my reading of Bourdieu's work, Bourdieu's emphasis lies on advocating acknowledgement for the limiting effect of structural factors on individual choice. After establishing that HIV interventions which solely address individual behaviour change fail to lead to comprehensive and consistent implementation of condom use in KwaZulu-Natal, I found relevance in Bourdieu's work. Thinking about the notions of habitus, field, and capital, has been helpful in identifying how structural properties influence individual behaviour. This thesis describes in detail how structural factors like *hlonipha* (expressing respect through avoidance), gender inequality, and peer pressure limit individuals from consistently implementing condom use.

2.3.2 Archer

This is not the only argument I wish to make. The thesis also brings attention to the improvisational strategies demonstrated by the participants. Chapter five, for example, shows how the parents' fear that their children could become infected with HIV causes them to provide their children with sexual education, despite this having been taboo for numerous generations. Parents apply different strategies to work around this taboo, which are described

in detail in chapter five. Chapter six attends to improvisation by the male participants who aim to act respectfully, whilst also living up to the latest pressures of masculinity. It describes couples who worry more about being seen together by their parents, than about having children outside wedlock. Similarly it describes girlfriends who worry more about their community finding out that their boyfriend is cheating on them, than the fact that their boyfriend is cheating on them. I refer to this improvisation as 'discreet indiscretions'. Finally, chapter eight, as a whole, attends to improvisation demonstrated by the participants, when some of them turn to alternative strategies instead of consistent use of condoms to reduce their individual risk of HIV infection. Chapter eight discusses in detail the three alternatives I was presented with by the participants; HIV counselling and testing, medical male circumcision and virginity testing. In my view these improvisations represent individuals who consciously reflect on their situation and aim to achieve the best results within the structural restrictions affecting their practice. By talking about subconscious strategies I feel that Bourdieu's concept of agency fails to explain fully these alternative strategies. As a result I have decided to turn to Archer's perception of agency.

Similar to Bourdieu, Archer is also a practice theorist. She describes the discrepancy between feeling both free to shape one's own future and enchained by towering constraints (Archer, 1988: xii). Although Archer acknowledges that structural and cultural properties create constraints and enablements that objectively shape the situations in which individuals find themselves (Archer, 2003: 135, 136), she points out that these constraints and enablements are not constraining or enabling per se. Archer argues that the influences of structural properties are not set in stone. Archer is critical of the way in which the majority of scholars focus solely on structural properties and their restricting influences on individuals' practices. This way, Archer argues, individuals are often "reduced to bearers of its properties" (Archer, 1988: xv). In her own work Archer emphasises the power of the individual and she reflects on the other, less considered, side of the story, namely how the individual receives and responds to structural properties. It is the relationship between the structural properties and the individual's project that will determine if and to what extent the properties will have an enabling or a constraining influence on the individual (Archer, 2003: 8).

By using the idea of 'projects', Archer introduces a more conscious side to practice. According to Archer individuals design projects, which suggest the intended course of action. "A project involves an end that is desired, however tentatively or nebulously, and also some notion, however imprecise, of the course of action through which to accomplish it" (Archer,

2003: 6). A project reflects the intention of an individual, which is not necessarily the same as the individual's practice, because the actual practice will depend on the influence of structural factors impinging on the project. In Archers' opinion "the subjective agent is the ultimate and effective cause of social practice" (Archer, 2003: 131, 134). According to Archer, structure and agency come together in the individuals' reflexive deliberations, which she also refers to as internal conversations. Through these internal conversations individuals reflect upon the structural properties that are impinging on their projects. Hence it is a matter of "agential subjectivity" reflecting upon "societal objectivity" (Archer, 2003: 130, 133). Archer argues for the ability of the individual to reflect on structural properties when confronted with new information. Large-scale or unpredictable events can rupture social convention. The assumptions that underlie the way we think are questioned only when something forces those assumptions to be made visible (Power, 2011: 159). Ellingson states:

> events disrupt the operative systems of ideas, beliefs, values, roles, and institutional practices of a given society. In so doing, events change the way in which social actors think about the meaning and the importance they assign to modes of action and the rules that govern interaction, groups and their discourses, symbols, and rituals (as quoted in Power, 2011: 159).

Although individuals have to respond to constraining and enabling influences, Archer points out that these structural properties are 'conditional' rather than 'deterministic'. When the constraints have been identified the individual can act strategically by looking for ways around the barriers so that the project will still be likely to have the wanted outcome, or they will adjust the project so that it will at least have the 'second-best outcome'. So these individuals make the best of the situation. In conclusion, Archer argues that the individual decides on the course of action after having evaluated how best to realize the project in circumstances that he or she cannot control (Archer, 2003: 6, 8, 133, 135).

2.3.3 Strategic individuals

Bourdieu has explained clearly how habitus influences the behaviour of individuals subconsciously. I remember the last night with my host-family when my host-father reflected on my stay with them. He lay down on the floor, put his legs on the couch and said: "you always ask questions, right now you probably want to ask me why I am lying like this, but let me tell you, not everything has a reason". Often, when I asked the participants why they did

what they did, they would be surprised by my question and would find it difficult to answer me. They would say: "this is just how we do these things". These were clearly practices that were motivated by practical sense, not conscious intentions. Habitus plays an important role in what practice people perceive as possible. Habitus frames their thinking, which means that they will not even consider alternative options. It is only when they are confronted with new information or with people who do the same thing differently, that these new ideas require their reflection.

I argue that the participants in my study are strategic individuals. The participants did not know much about HIV prevention or women's rights, before they became active in the health promotion field. In the health promotion field they learned about the importance of HIV prevention and that the use of condoms would offer the highest level of protection. Now that the participants are aware of HIV and what they could do to prevent HIV infection, their 'project' is to change the behaviour that is putting them at risk of HIV infection in the domestic field. Since the use of condoms is generally perceived as inappropriate in the domestic field (see chapter seven) they have to be creative and look for alternative routes to fulfil the same project, or otherwise reach a 'second-best outcome'. They do so by implementing alternative strategies (see chapter eight). These are practices that reduce the risk of HIV infection whilst still being acceptable to the habitus in the domestic field. If the best outcome, according to the health providers, would be condom use, then requesting sexual partners to go for regular HIV counselling and testing, medical male circumcision, STD treatment, etc. could be considered the 'second-best outcome', or an alternative route to still accomplish the project of HIV prevention.[9] So the participants have a feeling for the game. They know what is and what is not possible in the domestic field. They will alter the information that they gain in the health promotion field in such a way that it will be suitable or unnoticed in the domestic field, in an attempt to reach their goal of HIV prevention.

[9] It has to be noted that these alternatives do not offer the same level of protection as condom use would, and therefore are officially always promoted in combination with condom use.

Chapter 3: Individual awareness at the core of initial HIV interventions

3.1 Introduction

The introductory chapter has described the large extent of the HIV epidemic in South Africa. Now this chapter addresses what has been done to counter the epidemic. Seeing that there is no cure or vaccine for HIV/AIDS, the response world-wide has focused on prevention. This includes medical interventions: checking donor blood, preventing mother to child transmission, treatment of STDs, administering Post Exposure Prophylaxis (PEP) when a person has come into contact with the virus, and clean needle distribution for intravenous drug users. Recently it has also come to include medical male circumcision and in the future it might include female microbicide.[10] Prevention can also focus on behaviour change which aims to reduce risky sexual practice by for instance delaying sexual debut, reducing the number of sexual partners, and using condoms (Barnett & Whiteside, 2006: 352-358). It is this latter version of prevention, in particular the interventions that have been set up to promote safer sexual practice, that is central to this thesis.

How can an individual be motivated to choose safe over risky sexual practice? This question forms the basis of any HIV prevention intervention focused on behaviour change. Chapter two has argued that individual practice is not merely based on individual choice but is also heavily impacted by structural factors. However, this is not how the people who designed the early HIV interventions thought about it. They assumed practice was determined by individual choice. Consequently they believed that providing individual HIV awareness would bring about the proposed behaviour change (Barnett & Whiteside, 2006: 79). For their initial response to the HIV epidemic, the WHO turned to psychologists for advice on behaviour change. In 1987 the WHO created the Global Programme on AIDS (CDC, 2012) which became UNAIDS in 1996 (UNAIDS, 2012a). This programme, created at the head office in Geneva, was implemented in more or less the same form in Africa, Asia and South America. The programme was based on western psychological models, more particularly social cognition models (Barnett & Whiteside, 2006: 79). These social cognition models aim to predict behaviour change, more particularly the willingness of an individual to engage in health care behaviour, e.g. regular exercise, healthy diet, smoking cessation, dental check-ups,

[10] Female microbicide is a gel that can be applied inside the vagina to protect a woman against STDs including HIV.

smear tests, vaccinations, breast self-examination, etc. (Terry, Gallois, & McCamish, 1993: 1). These models have, to some extent, been successful in predicting health practice and therefore they were the first models to be used when setting up HIV prevention interventions (Abraham, 2008: 138, 139).

Despite the models' success in predicting particular health behaviour, when it came to predicting sexual health behaviour the models failed (Warwick, Terry, & Gallois, 1993: 118). This chapter, and the rest of this thesis, explains why interventions aimed at individual awareness often do not result in the promoted behaviour change. Instead of the universal and individual solution promoted initially by the Global Programme on AIDS, it argues for a context-specific intervention that pays attention to the collective instead of merely focusing on the individual.

This chapter starts with a description of the social cognition models, which is followed by an anthropological criticism of these models. The criticism addresses examples of structural factors that affect individual decision making regarding HIV prevention. Besides criticizing initial HIV interventions for being solely focused on individual HIV awareness, this chapter also criticises the interventions for promoting condom use as the only solution. The chapter ends with a description of the two NGOs at the centre of this thesis which have established that individual HIV awareness is insufficient to create behaviour change. Both NGOs have identified how gender inequality affects individual choice. However, as the description will show, each NGO has addressed this issue in a different manner.

3.2 Social cognition models

The initial response to the emerging HIV epidemic considered behaviour change as an individual psychological issue and based its interventions on the following three social cognition models; the health belief model, the theory of reasoned action, and the theory of planned behaviour.

The health belief model, a model that aims to explain health related behaviour, was developed in the 1950's by a group of social psychologists at the United States Public Health Service (Barnett & Whiteside, 2006: 80; Janz & Becker, 1984: 41). They had observed that a considerable number of people did not take the opportunity to prevent disease or to undergo screening tests for the early detection of asymptomatic disease, even when this was offered free of charge or at a low cost (Janz & Becker, 1984: 2). The model was used to establish what needed to be in place for healthy individuals to take action to remain healthy (Janz & Becker, 1984: 1; Rosenstock, 1974: 328; Stroebe, 2011: 24). According to the health belief

model individuals ask themselves the following three questions to determine their attitude towards an illness prevention strategy. Am I likely to get the illness? How bad would it be if I got it? Is it feasible to take up the prevention strategy? So they consider their susceptibility and the severity of the disease to determine the level of threat the disease poses. Their actual behaviour will be determined by considering whether the strategy would reduce the threat of the disease at a reasonable cost. In this case cost does not only refer to money, but also to discomfort and embarrassment.[11] If the above questions have resulted in a positive attitude towards the promoted strategy, there is often one more factor needed to instigate an individual to take on the strategy. This factor Rosenstock refers to as a 'cue to action'. This could be a bodily symptom, like a cough, reminding the individual, it could also be a reminder notice from the dentist, or it could be someone close to the individual getting diagnosed with the illness (Abraham, 2008: 141; Mays et al., 1989: 112; Rosenstock, 1974: 333, 332; Stroebe, 2011: 25).

The second social cognition model is the theory of reasoned action which was first introduced in 1967. This model considers individuals as rational actors and suggests that individuals make behavioural decisions on the basis of a deliberative consideration of available information (Mays et al., 1989: 94, 95; Terry et al., 1993: 7,8). Furthermore, this theory proposes that intention predicts actual behaviour (Terry et al., 1993: 24). Intentions are formed by weighing up the subjective norm (the individual's perception of how people who are important to them expect them to behave) against the motivation to comply (Jemmott & Jemmott, 1991: 228; Stroebe, 2011: 61; Terry et al., 1993: 8, 13; Warwick et al., 1993: 120). To change behaviour, intentions need to be altered. This requires both a change in individual beliefs and a change in normative beliefs (Mays et al., 1989: 109).

The third model is the theory of planned behaviour, which, similarly to the theory of reasoned action, acknowledges the importance of attitude and subjective norms as significant predictors of behavioural intention. However, to improve the predictive power of the model, the theory of planned behaviour adds the importance of perceived behavioural control, also known as self-efficacy. Self-efficacy refers to the individual's self-confidence. Does the individual believe that he or she is able to implement the behaviour? When people have the self-confidence and feel they are in control of their health, they are interested in engaging in

[11] (Abraham, 2008: 140; Janz & Becker, 1984: 2; Rosenstock, 1974: 330, 331; Stroebe, 2011: 24, 25; Terry et al., 1993: 1; Warwick et al., 1993: 117; Zamboni, Crawford, & Williams, 2000: 493)

health behaviour and they put it into practice. However, when people are not convinced they can do it, they are unlikely to pursue health preventative behaviour and the likelihood of risky behaviour increases (Abraham, 2008: 141, 143, 158, 171-173; Janz & Becker, 1984: 44; Mays et al., 1989: 129; Stroebe, 2011: 26, 27, 36; Terry et al., 1993: 4, 24).

As the social cognition models evolved from the health belief model to the theory of reasoned action and eventually the theory of planned behaviour, the models became more accurate in predicting health behaviour. The theory of reasoned action started to acknowledge the impact of social influence on behaviour by adding the concept of 'subjective norm' (Stroebe, 2011: 27). Another improvement was when the theory of planned behaviour added self-efficacy to its model. The advanced models were relatively successful in predicting health behaviour when it came to matters such as quitting smoking, taking up exercise, and getting vaccinated. This success is what motivated initial HIV interventions to follow these social cognition models.

3.3 Anthropological criticism of the social cognition models

Although anthropologists generally did not agree with the individual focus central to the social cognition models, during the early years of the HIV epidemic they were reluctant to make any alternative suggestions. Instead they remained quiet on the topic of sexuality. Anthropology's dubious legacy when it came to studying sexuality has been identified as a cause for this initial reluctance. Early anthropologists, officially explorers and missionaries, had written several wild accounts about the sexuality of the 'savages' they encountered in Africa to the extent that it has been referred to as 'ethnopornography' (E. C. Green & Herling Ruark, 2011: 23, 24). Due to this sensitive history anthropologists had purposely kept away from the topic of sexuality between the fifties and the eighties (E. C. Green & Herling Ruark, 2011: 23, 24). Sexuality was considered an illegitimate topic of study for anthropologists. A researcher studying sexuality would have their motive and character questioned and supervision and funding would be hard to find. The anthropological studies that did address sexuality in those years mainly described sexual institutions like initiation rituals, marriage, and reproduction. They did not discuss actual sexual experiences (E. C. Green & Herling Ruark, 2011: 25; Spronk, 2006: 6; Vance, 1991: 875, 879).

In the 1990s 'culture' was identified as an element affecting sexual behaviour, in an attempt to explain why HIV was spreading more quickly in certain populations. Suddenly attention turned to anthropologists who were asked to gather contemporary information about sexuality in different cultures (E. C. Green & Herling Ruark, 2011: 23, 24, 33, 65). In those

years the time pressure on research was enormous. Researchers were told that the longer it would take them to produce their recommendations, the more people would die of AIDS (E. C. Green & Herling Ruark, 2011: 24; Schoepf, 2001: 340; Vance, 1991: 881). As a result anthropologists became involved in producing superficial rapid ethnographic assessments, rather than the more detailed ethnographies they were trained to produce (R. Parker, 2001: 170). Out of these rapid ethnographic assessments came descriptions of African sexual practices as exotic, irrational, traditional, immoral, excessive, and diseased. This was not too dissimilar to the descriptions from the early anthropologists, explorers, and missionaries. Instead of attending to a wide range of contextual factors in these reports, African culture was blamed for the spread of HIV (E. C. Green & Herling Ruark, 2011: 24; Schoepf, 2001: 340, 341; Spronk, 2006: 9, 11).

This made it harder again for the next anthropologists to become involved in sexuality research. However, when they finally did they expressed their criticism of the a-social approach of the social cognition models. They argued that these models assume, first, that health is the result of individually chosen lifestyles. Second, they assume that an individual consciously considers the information available to him or her and the consequences of their potential actions, before the individual determines his or her course of action. Finally, they assume that it is the individual who determines what he or she will do, not the social environment. The focus of these models is on individualism and individual responsibility and even when the theory of reasoned action introduced the notion of subjective norm into its model, its meaning was limited to a consideration of the individual's perceptions of these social phenomena (Kippax & Crawford, 1993: 253, 255; Rosenstock, 1974: 329; Schoepf, 2001: 339; Stroebe, 2011: 12, 24; Vaughan, 1991: 6; Warwick et al., 1993: 132).

Anthropologists and other social scientists argue that individual HIV awareness is insufficient to produce behaviour change, because it ignores how structure influences the practice of an individual, as argued in chapter two.[12] An individual does not practice in isolation from other individuals (Cockerham, 2007: 54). Cockerham explains that individuals make decisions as part of collectivities: "collections of actors linked together through particular social relationships, such as kinship, work, religion and politics. Their shared norms, values, ideals and social perspectives constitute intersubjective "thought

[12] (Abraham, 2008: 158; Allen, 2004; Barnett & Whiteside, 2006: 358; Campbell, 2003; Dinkelman, Livinsohn, & Majelantle, 2006; Kippax & Crawford, 1993: 253, 254, 263; Korp, 2010: 800; Mays et al., 1989: 309; R. Parker, 2001: 165; Sathiparsad, 2007: 193; Schoepf, 2001: 339, 343; Swidler, 2009: 136, 144; Tadele & Kloos, 2013; Thornton, 2008)

communities" beyond individual subjectivity that reflect a particular collective world view" (2007: 65). Health beliefs are not formed by cognitive processes. Instead individuals follow intuitively what someone in their position is disposed to do (Cockerham, 2007). Individuals make sense of information given to them intersubjectively through their interactions and conversations with other people (Kippax & Crawford, 1993: 262, 264). New knowledge will always be interpreted in the context of pre-existing collective norms (R. Parker, 2001: 167). Thus instead of focusing on convincing individuals to change their behaviour, prevention should intervene at the collective level (interpersonal, organizational, community, or national) and focus on changing the collective norm to enable individuals to change their behaviour (Abraham, 2008: 183; Swidler, 2009: 149; Thornton, 2008: 86, 93). This even applies to sexual practice (Abdool Karim & Abdool Karim, 2005; Kippax & Crawford, 1993; Korp, 2010; Mays et al., 1989; Thornton, 2008). Although sexual behaviour might seem intimate or private, it is actually a "social act motivated by social meanings which are public and negotiated with other members of society and therefore properties of culture that exist at a scale larger than the individual" (Thornton, 2008: 29). Sex is "as much about nature as it is about culture, as much about individuals as it is about society" (Spronk, 2006: 16).

Take for example the practice of condom use. To speak of condom use as if it is merely an individual decision is misleading. Whether or not an individual decides to use a condom is socially constructed; based on cultural values and collective norms regarding sexual practices. If the general opinion speaks out against the use of condoms, then it will be hard for an individual to suggest condom use (Jemmott & Jemmott, 1991: 233). A clear example of this can be found amongst the gay community in San Francisco as described by Dean (2008) and Hogarth (2003). The gay community in the USA, Europe and Australia have been described by many researchers as committed to condom use during the early years of the HIV epidemic (Barnett & Whiteside, 2006; M. Cohen, 1991; Dean, 2008; Kippax, 2010; Power, 2011; Vance, 1991). In the eighties and early nineties using a condom with a casual partner was the accepted and also the expected thing to do to prevent the transmission of HIV. At that time, AIDS was considered a deadly disease and HIV positive gay men were suffering both physically and socially. However, less than two decades later, the discovery of ARVs has caused some gay men to consider HIV as a chronic disease. Believing that sooner or later they will become infected, these men make the conscious decision not to protect themselves. Dean studied 'barebacking' practices among urban gay communities in San Francisco. Barebacking refers to anal sex without the use of a condom (Dean, 2008: 84). Dean stresses

that barebacking is not the same as having unsafe sex, because having unsafe sex could still be considered a mistake, whereas barebacking is a conscious decision. Within the bareback community it is the HIV positive people that receive the highest status and the HIV negative people that feel marginalised. Doug Hitzel is one of the people interviewed in the documentary 'the gift'. He described how he came to San Francisco as a young, insecure and lonely gay man. Upon his arrival he was confronted with a gay scene in which people who were suggesting the use of condoms were stigmatised and described as "the freak in the corner". Instead of feeling the pressure to have safe sex, he felt pressured into having unsafe sex. Hitzel stated that only when he started to have unsafe sex did he feel that people wanted him around and that he was fitting in (Hogarth, 2003). The barebacking community consists of men who have been at the receiving end of HIV prevention programmes for many years (Dean, 2008). They know what they would have to do to prevent HIV transmission, yet they make the conscious decision to expose someone else or to be exposed to the virus. It is clear that in this case a lack of knowledge cannot be blamed for their risky practice. Hitzel explained that despite having grown up with the HIV prevention message, he eventually decided to have unsafe sex to "fit in" (Hogarth, 2003). The barebacking example shows that it is easier to follow the general opinion than it is to go against it. Hence, it shows how individual practice is heavily impacted by structural properties.

The above example describes a gay community in the USA, whereas this thesis studies heterosexual relationships in KwaZulu-Natal. Despite the obvious differences, the participants in this study also make decisions as part of collectivities and also interpret new information in the context of pre-existing collective norms. Chapter seven describes how the participants speak differently about the use of condoms in different fields. When the participants are at the NGO they describe condom use as the ideal strategy to prevent HIV transmission. However, when they are amongst their peers they speak of condoms as spoiling the sexual experience, as symbolising a lack of trust, and as a strategy that can only be suggested by men. Chapter seven discusses how these different collective norms affect individual decision making regarding the actual implementation of condom use.

At the turn of the century, people in the field of HIV prevention started to move away from the individual centred understandings of the epidemic, towards an understanding of AIDS as fuelled by socio-economic factors such as poverty, lack of education, racism, gender inequality, sexual oppression, social exclusion and other forms of discrimination (E. C. Green & Herling Ruark, 2011: 37; R. Parker, 2001: 168). All of these factors make individuals more

vulnerable to HIV infection (Schoepf, 2001: 354). It could be that poverty overrules the threat of HIV. Instead of being worried about an illness of which the symptoms remain dormant for up to ten years, individuals might be in a situation in which they are struggling to provide food for their children on a daily basis. In the search for financial support they might resort to strategies that place them at an increased risk of HIV infection, like transactional sexual relations or migrant labour (E. C. Green & Herling Ruark, 2011: 37). People in these situations cannot always make long-term health matters their top priority (Janz & Becker, 1984: 44). These structural factors restricting individual choice have been overlooked by the social cognition models.[13]

Campbell (2003) has studied a culture of tough masculinity that encourages multiple sexual partners in the risky mining industry in South Africa, and Farmer (1999), described the situation of poverty-stricken women in Haiti who were involved in risky sexual relationships for financial support. Authors like these have been pioneers when it comes to describing the context in which people negotiate sexual relationships to illustrate how socio-economic factors can affect HIV risk behaviour (E. C. Green & Herling Ruark, 2011: 37; R. Parker, 2001: 170). Farmer argues that structural factors, which he refers to as structural violence, should be attended to when thinking about HIV prevention (Farmer, 1999). Overall it is not the individual that needs to be convinced of the importance of preventing HIV transmission, it is their situation of poverty and discrimination that needs attention, to enable them to prevent HIV transmission (E. C. Green & Herling Ruark, 2011: 37, 71). If poverty is not addressed, HIV campaigns will be to no avail. To emphasise this point Schoepf explains that AIDS has also come to stand for Acquired Income Deficiency Syndrome (2001: 342).

Those who, despite being well-informed about HIV and HIV prevention, fail to practice HIV preventative behaviour have at times been judged by policymakers as acting irrationally. This has led to racist assumptions about African sexuality. However, when taking the time to understand the context in which these people have to negotiate sexual relationships, it

[13] Over the years, health providers have acknowledged the impact of social processes on disease. A classic example of this is the 'Ottawa Charter for Health Promotion', established in 1986. This charter looks for determinants of health beyond the individual, realising that outside factors, like unrest, poverty and inequity, can influence health. Hence it attends to the broader social context in which the health related behaviour of an individual takes place and it focuses on making these external conditions suitable so that an individual can improve his or her own health (WHO, 2012b) However, according to Leclerc-Madlala, this understanding has yet to be adapted to the majority of HIV prevention programmes (2011: 785).

becomes clear that HIV prevention is not the only thing these individuals have to worry about. They also have to consider how the suggestion of condom use could lead to a potentially violent response, or the end of a relationship and thereby the loss of income and status (Schoepf, 2001: 348). Individuals choose the best or in this case the least harmful option. Due to socio-economic factors their options are limited. As chapter two has argued, although socio-economic factors can obstruct individual choice, individuals are not powerless. They have agency (Abdool Karim & Abdool Karim, 2005: 146; E. C. Green & Herling Ruark, 2011: 191). Underestimating agency ignores the fact that individuals are also active agents in their own lives who can negotiate and are able to manipulate structures and think of alternative strategies to reach their goal (Vance, 1991: 877, 881). Yet overemphasising agency, comes with the risk of blame when individuals do not take on the promoted health behaviour (Schoepf, 2001: 347).

When it comes to contextual descriptions, anthropological methodology can make an immense contribution (E. C. Green & Herling Ruark, 2011: 76; Schoepf, 2001: 337). Long-term participant observation allows anthropologists to move beyond snapshots, to describe the participant's everyday lives, and to explain the meaning of the participants' behaviour (Heald, 2006: 31). Instead of describing sexual behaviour from an ethnocentric perspective, anthropology aims to give an emic description to understand behaviour in its context and not by the standards of western culture (E. C. Green & Herling Ruark, 2011: 21; Schoepf, 2001: 350). It is ethnographic research like this that has been able to undermine racist theories about African sexuality (R. Parker, 2001: 171).

3.4 Fixation on condom promotion

The problem with HIV interventions has not only been the focus on individual awareness, but also the focus on promoting condom use as the key HIV prevention tool. The earliest response to HIV was centred in the USA where HIV spread quickly among the gay population during the early years of the epidemic. The gay community stood out as activists and heavily contributed to mobilising funding, research, treatment for people infected with HIV, and also the content of prevention campaigns (E. C. Green & Herling Ruark, 2011: 65). The fact that the gay community in the 1980's successfully reduced HIV transmission within their community, resulted in their best practice, which was condom promotion, dominating the content of HIV prevention programmes throughout the USA and later also in Africa (E. C. Green & Herling Ruark, 2011: 66; W. Parker, 2012: 231; Swidler, 2009: 149). Swidler argues that when organisations fund HIV interventions, they often also have a considerable influence

on the content of HIV prevention campaigns and the majority of African HIV interventions are funded by American organisations. It is for this reason that initial HIV interventions in Africa followed best practice of the gay community in the USA; meaning individual HIV awareness and condom promotion (E. C. Green & Herling Ruark, 2011: 68; Swidler, 2009: 130, 149).

As it turned out, condom promotion did not lead to a decrease of HIV prevalence in African populations (E. C. Green & Herling Ruark, 2011: 69). African communities did not take to condoms the way American gay communities had done. First, whereas the gay community had largely come to accept the HIV epidemic as a serious threat to them and had tackled the problem head on, African communities had generally distanced themselves from HIV and mainly responded with denial. The majority refrained from protecting themselves, because they did not feel personally at risk of HIV infection. According to Barnett and Whiteside, this was caused by the emphasis that there had been in prevention campaigns on 'risk groups', like prostitutes, homosexuals, intravenous drug users, and haemophiliacs. People outside these alleged 'risk groups' considered themselves safe from HIV infection (Barnett & Whiteside, 2006: 346). Second, African communities were suspicious of condom promotion because it affected reproduction. This is discussed more fully in chapter seven. Third, whereas in the gay community condoms were associated with caring about one's sexual partner, in African communities the suggestion of condom use was associated with a lack of trust. This made it hard to suggest condom use. Furthermore, the long-term heterosexual relationships in which condoms had to be introduced were very different from the homosexual relationships in the USA. For instance gender inequality made it difficult for women to suggest or insist on the use of a condom (E. C. Green & Herling Ruark, 2011: 65-69).

To illustrate that the western top-down, individual-aimed, and condom-centered approach did not result in HIV reduction in most parts of Africa, I will compare Botswana and Uganda's HIV prevention strategies. Botswana's intervention followed western models for intervention, whereas Uganda developed its own strategy. Botswana is a relatively wealthy African country. When HIV emerged the political situation in Botswana was stable and the government was committed to tackling the epidemic. Botswana followed the advice from the international public health community and as a result they introduced a top-down, applied intervention programme which provided individual HIV awareness and promoted the ABC approach (abstain, be faithful, or condomise). Despite individuals being well-informed on

HIV/AIDS, this failed to result in behaviour change. In Botswana the HIV prevalence went from 18.1% in 1992 to 36.3 % in 2001 (Swidler, 2009: 132-137).

The situation in Botswana has been analysed by different authors and the following reasons are given for why, despite its efforts, Botswana failed to reduce its HIV prevalence. First, in hindsight the committed government seems to have responded too quickly. They responded before the impact of the HIV epidemic had been noticed by the people in local communities, before they had any personal experience with it. This meant that when the interventions started, people had only heard about this disease in the media. HIV became known as the "radio disease" and the actual existence of HIV was questioned. Hence, HIV was considered a foreign disease, not an internal one. Due to this detachment people did not consider it necessary to change their behaviour. Hence the population of Botswana did not accept HIV as their problem; instead they were in denial and 'othered' the risk of infection. As a result they lacked commitment. Second, years of efficient, centralized government had made local councils superfluous and disappear (Allen & Heald, 2004: 1144, 1147, 1150). This made it harder to mobilize local communities. As such, Botswana lacked an energized, vigorous, autonomous NGO sector (Swidler, 2009: 137, 142). Without this NGO sector there was no local input into the HIV prevention programmes, which followed western models instead. As a result the programmes did not connect to the daily life of the people 'on the ground'. Condoms were promoted despite antipathy from church groups, local healers, parents and chiefs (Allen & Heald, 2004: 1145, 1146, 1151). Later in the epidemic Botswana changed their approach and only then the HIV prevention programmes started to be more successful. The biggest change in Botswana's approach was that they took responsibility and acknowledged their risk. The President, who was feeling unwell at the time, openly admitted his fear of being HIV positive. He decided to be tested. By linking himself to HIV infection he demonstrated that HIV infection could happen to anyone in Botswana; that nobody was safe from HIV. This way the President initiated responsibility and broke the circle of stigma and denial (Heald, 2006: 39).

Compared to Botswana, Uganda's HIV prevention programmes were surprisingly successful. Despite being a much poorer country than Botswana, Uganda lowered its HIV prevalence in ante-natal clinic attendees from 29.1 % in 1992 to 11.2 % in 2001 (Swidler, 2009: 133). The following reasons are given to explain Uganda's success. First, in Uganda the governmental approach was distributed and decentralized. HIV prevention was promoted through mass mobilisation which linked politicians, chiefs, churches, NGOs (international,

national, and local), journalists, pop stars, soldiers, doctors, teachers, etc. (Barnett & Whiteside, 2006: 348; Swidler, 2009: 133, 137, 141). Second, although Uganda officially promoted the ABC approach, condoms were not vigorously promoted (they were considered un-African, their effectiveness was questioned, and the President had openly expressed negative attitudes towards them), nor were they widely available. As a result condoms did not play a primary role in reducing HIV transmission in Uganda. Instead it was the decline in multiple concurrent relationships and the delay of sexual debut for girls that made the difference (Allen & Heald, 2004; Thornton, 2008: 85-96). One of the campaigns promoted was the locally designed and community-run campaign called 'zero grazing' which warned people about the risk of multiple concurrent relationships (Epstein, 2007; E. C. Green & Herling Ruark, 2011: 76; Swidler, 2009: 132, 137). Third, from the beginning the President had made the fight against AIDS a national crusade. The President addressed HIV in every speech he gave, and he demanded the same thing of any other official from national politicians to local chiefs (Swidler, 2009: 135, 146).

Comparing HIV interventions in Botswana with HIV interventions in Uganda illustrates that, compared to individual HIV awareness, mass mobilisation is more effective in creating individual behaviour change. Public health campaigns designed by international donors, like the one in Botswana, failed to make a difference, because these campaigns were directed at individual HIV awareness (Abdool Karim & Abdool Karim, 2005: 151; Benotsch et al., 2004: 332; Swidler, 2009: 130, 134). This chapter has already explained that individual interest is not enough to create individual behaviour change, because individual practice takes place in a collective, social context. Hence prevention needs to be community based and needs to aim at transforming collective norms in ways that promote HIV preventative behaviour (W. Parker, 2012: 168, 172; Schoepf, 2001: 349; Swidler, 2009: 145). The few programmes that mobilized the entire community to fight the epidemic, like the one in Uganda, were successful (Benotsch et al., 2004: 332). Swidler argues that decision making in Africa is influenced more by the sense of moral identity, shared fate, and commitment to others, than by individual preferences (Swidler, 2009: 144, 148). According to Swidler if you want to create change, you have to change the 'normative ferment' instead of changing the opinion of one individual (Swidler, 2009: 132). The success in HIV reduction among the gay community also confirms this theory. Although this has often been interpreted as the success of condoms, the actual message to take home, according to Swidler (2009), Epstein (2007), and Power (2011) is that this was also a case of social mobilisation. Gay men did not use condoms to

protect themselves from dangerous men; instead they used condoms to signify their love for other men and their commitment to their community.

The comparison between Botswana and Uganda also shows that locally inspired interventions are more effective than global ones. Similar to Botswana, South Africa's initial HIV intervention programmes also followed a top-down standardized global model, instead of considering the needs and the context of the affected communities or letting the people 'on the ground' have a say in the interventions. These HIV prevention programmes failed to significantly reduce new HIV infections (W. Parker, 2012: 230-236). Schoepf (2001: 350) has found that HIV interventions that attend to local structures and values around sexual socialization and that establish how HIV prevention can be appropriated within those structures and values are more effective than HIV interventions that merely copy western solutions. This is what happened in Uganda where a bottom-up approach was used. Ugandans themselves identified problems, generated solutions, and created close knit networks of mutual support through local communities and organisations (W. Parker, 2012: 231; Thornton, 2008: 85).

Finally comparing Botswana and Uganda has demonstrated the importance of creating acceptance and responsibility. The final reason why Uganda was successful in bringing down the HIV prevalence had to do with decisive political and civic leadership (W. Parker, 2012: 231). The President spoke about HIV often and openly which helped to avoid stigma surrounding the disease (Swidler, 2009: 141). Unlike the President of Botswana, the President of Uganda acknowledged the HIV epidemic as a serious threat to the country. He made HIV prevention not only about protecting oneself, but also and more importantly about protecting one's community. As such, preventing HIV transmission was not considered an individual matter, but became a nation building exercise. Thornton has the following explanation for why Uganda immediately acknowledged HIV as their problem and tackled the disease quickly: before AIDS was called AIDS and before overseas organizations came to Uganda to talk about HIV prevention, Ugandans already had experience with a new illness affecting their communities, which they called *Siliimu*. It had entered cultural consciousness, oral history, and vocabulary, before Ugandans were warned by the government or international NGOs. As a result they did not consider AIDS as foreign and therefore they were not suspicious towards the interventions either (Thornton, 2008: 83, 91, 100, 115, 148).

The above has given an idea of the globally constructed and condom focused HIV intervention model that initially shaped South Africa's HIV interventions. Chapter eight of

this thesis demonstrates how more recently South Africa, led by President Zuma, has started to follow Uganda's example of political and civil commitment, social mobilisation and context suitable HIV prevention strategies.

3.5 Gender inequality

Local NGOs can serve as bridges between the government or international donors and the at-risk community. They either consist of, or are closely in touch with, the people at the receiving end of the interventions. As such they are in a great position to contribute to establishing culturally sensitive prevention programmes (Benotsch et al., 2004: 321). As Uganda's example has shown, it is this bottom-up approach that has proven to be most successful in reducing the spread of HIV. This is why it is interesting to have a look at local NGOs. For this thesis I visited two local NGOs working on HIV prevention in KwaZulu-Natal. These organizations were established by people from the local communities and are thus very different from 'top down' organisations.

One structural factor restricting individuals from taking on HIV preventative behaviour is gender inequality.[14] Tallis states: 'only when gender inequality becomes a central part of HIV/AIDS programmes, can we hope to make an impact on the course of the epidemic' (Tallis, 2000: 58). According to Zulu gender norms, women should keep quiet while men make decisions regarding sexuality. As a result women are unlikely to suggest a change in sexual practice, and if they did, men would be unlikely to accept these suggestions. The fear of losing status and of upsetting a sexual partner (which could result in the loss of the relationship or violence) keeps women from negotiating HIV prevention (Sathiparsad, 2007: 173). Hence, it has been reported that negotiation regarding sexual practice is limited (Bonnin, 2000: 306, 315; Maharaj, 2001; Mfecane et al., 2005: 89). This means that even if women have knowledge about HIV, they are likely to struggle to implement it (Abdool Karim & Abdool Karim, 2005: 254).

Both NGOs at the centre of this thesis identified gender inequality as a major complication in the implementation of HIV preventative behaviour. In response the first NGO (Women and Children First) works predominately with female staff and has made female empowerment an important element of their ideology. The second NGO (Bafana AIDS Project) has taken

[14] (Abdool Karim & Abdool Karim, 2005; Bonnin, 2000; Gollub, 2006; Gordon, 1995; Maharaj, 2001; Mfecane, Struthers, Gray, & Mc Intyre, 2005; Sathiparsad, 2007: 173; Susser & Stein, 2004; Tallis, 2000: 59; Varga & Makubalo, 1996)

another approach and decided to work predominantly with male staff and made responsible masculinity an important element of their ideology. The remainder of this chapter introduces the work of these two NGOs.

3.5.1 Female empowerment

The first strategy that was developed to deal with gender inequality focused on improving the position of women. By empowering women, the inequality between men and women was to be reduced. Female empowerment developed into a buzzword, but the exact meaning has often remained unclear. Instead the concept has been used according to people's own interpretation (W. James, 1999: 14). Inspired by Tallis (2000), Ndinda, Uzodike, Chimbwete, and Mgeyane (2011), Kenny and Camenzind (2007), and Sen and Batliwala (2000), I use empowerment in the following way: empowerment is the process by which individuals who are considered powerless gain greater control over their own lives. By gaining knowledge and skills these individuals develop the ability to think critically, their self-confidence is strengthened, and they become more independent. As a result they can overcome structural barriers, access resources, or deviate from the norm.[15]

Empowerment can contribute to HIV prevention by increasing a woman's control over her sexual relationships. By gaining both negotiation and refusal skills she can better control when she has her sexual debut, when she starts a family, and what HIV prevention techniques she would like to use (Sen & Batliwala, 2000: 26; Yankah & Aggleton, 2008). Finally, financial independence is also an important element of empowerment. When a woman is no longer financially dependent on her sexual partner, it becomes easier for her to leave a relationship if it obviously poses an HIV risk (Susser & Stein, 2004: 137, 143).

[15] The term empowerment is closely linked to a bottom-up approach, which can be clearly identified in the words that often accompany the concept of empowerment: inclusiveness, transparency, accountability, community development through self-help, collective decision making, collective action, popular participation, local self-reliance, participatory democracy, room for indigenous knowledge and self-sufficiency (Singh & Titi, 1995: 13, 14). Nevertheless, Tandon questions if empowerment is truly a bottom-up approach. Tandon states that the empowerment referred to by the development industry is generally initiated by people in power. This means that these people will manage and condition the power. They speak of empowerment as if power is for them to give away. As such it has become a top-down process after all. This means that empowerment is a contradiction in terms. Tandon argues that in genuine empowerment, power should not be given, but should be taken instead. Therefore 'there can only be self-empowerment' (Tandon, 1995: 33, 34).

3.5.1.1 Women and Children First

An example of an NGO that has focused on female empowerment is 'Women and Children First'. This is the first NGO I looked at as part of the research. The NGO was founded by Robyn. She was born in 1952 to English immigrants who settled in Zimbabwe as part of a 'colonize the colonies' programme. Her childhood became troubled when at the age of ten Robyn lost her father. From that moment her mother was left to raise four children alone. Instead of going to school Robyn had to look after her younger siblings while her mother went out to work. During these years Robyn experienced first-hand poverty and sexual abuse. She married at a young age and moved to South Africa to a seaside town thirty kilometres south of Durban. She was, and still is, known as a 'rebel' who upset the established order when she felt that people were treated unfairly. In South Africa she spoke out against apartheid and in 1987 she challenged members in her church who portrayed HIV as a disease of sin. She also *toyi-toyed* (a dance step characterized by high-stepping movements, typically performed at protest gatherings or marches) in front of parliament to lobby for more compassionate care for AIDS patients and access to treatment. In the early nineties she became aware of cases in which children around the age of ten were HIV positive. Robyn realised that they were too old to have been infected through birth. Instead she found out that they were HIV positive because they had been sexually abused. Since 1990 hospitals had PEP[16] available for their doctors and nurses in case of a needle prick incident. Robyn lobbied hard to make PEP available to victims of sexual abuse.

One Wednesday morning in 1996, the realisation of the looming HIV epidemic became too much for Robyn. She broke down in tears under a large tree next to the road. Worried about this white woman's wellbeing and safety, Precious, a stranger at the time, sat down next to her. They spoke for hours about the problems that HIV had brought to the local communities. Although Robyn lacked money to provide any financial help, as a trained HIV educator she offered to teach Precious and her friends about HIV. The next Wednesday Precious arrived at the tree with thirty women. This is how the 'Tree Clinic' was founded. Every Wednesday since, members of surrounding communities walk considerable distances to the tree. Here they share information and experiences of pressing issues like HIV, violence, housing shortage, and sexual abuse. As they talk and pray they find support in each other. Sometimes

[16] PEP consists of ARVs and can reduce the risk of HIV transmission up to 81% if administered within 72 hours of coming in contact with the virus. For more information see Maureau (2007).

Robyn invites guest speakers, including people who openly live with HIV. Over the years the tree has become a large operation. Besides the information sharing and the support group interaction the tree has also become a place where food, clothes and toy donations are handed out. Furthermore, a large medical box and volunteers provide basic health care. Attendants can also request assistance with grant applications.

Hence, every Wednesday Robyn is in close contact with the local communities. She finds out from the people 'on the ground' what the pressing issues are. The 'tree clinic' was the informal start of Robyn's NGO. In 2000 she founded 'Women and Children First'. Besides the 'tree clinic', the NGO also works directly with child 'survivors' of sexual abuse. The NGO brings these children to safety by removing them from the abusive setting and by taking them to the medical clinic where they are treated for their wounds and receive PEP treatment. After this immediate help, the NGO also provides counselling to deal with the child's trauma and assists the child in court. Another branch of the NGO promotes HIV prevention. Robyn and her gradually growing number of staff members visit schools, clinics, churches, and community centres in the surrounding communities to provide HIV prevention and sexual abuse awareness. Over the years 'Women and Children First' has evolved into a well-established organisation which is financially supported by several foreign donors. When I joined them in 2010 and 2011, the organisation employed ten community HIV educators (nine Zulu women and one English woman). There were also roughly five supporting staff members (an accountant, a driver, a child minder, a pro-bono psychologist, and a carpenter), but the focus of this thesis is on the community HIV educators. These women were in their thirties and forties and came from different townships and rural areas surrounding the seaside town where 'Women and Children First' had based itself. Robyn found most of her staff members at the tree clinic. Despite their limited education they stood out to Robyn for their passion for the children and their community. As part of her empowerment ideology Robyn aimed to make these women financially independent; creating a situation in which they did not have to rely on a sexual partner to make ends meet. She did this by offering them a salary, providing them with breakfast and lunch at the NGO, and through offering them clothes and toys from the donation box. Furthermore, she encouraged them to extend their skills by gaining qualifications (e.g. an HIV counselling and testing course, first-aid course, counselling course, driving licence, etc.). An analysis of how the capital that the women gained by working at Robyn's organisation enabled them to reduce their risk of HIV infection follows in chapter six.

3.5.3 Responsible masculinity

The above has shown how the response to gender inequality has led to attempts to facilitate female empowerment. The following section deals with a different school of thought when it comes to addressing gender inequality initiated by those who believed that female empowerment further victimises women. The people involved in this school of thought, academics, activists, policy makers, and people in the community running local NGOs, observed that the notion of gender had become directly associated with women, gender equality only involved female empowerment, and women were generally held responsible for sexual health and contraception (Bujra, 2000: 7; Ruxton, 2004: 217; Seidler, 2006: 185; Shefer, Ratele, Strebel, & Shabalala, 2005: 74, 76). As Grange summarises it "the very projects that sought to 'free' women have, unwittingly, led to their further victimization" (Grange, 2004: 103). Men, on the other hand were mainly ignored or marginalised by HIV interventions (Shefer et al., 2005: 74, 76). They were generally depicted as largely incapable of controlling their sexual behaviour and were therefore exempted from the responsibility of HIV prevention (Gibson, Dinan, & McCall, 2005: 154). However, in Zulu culture sexuality is dominated by men. Men make the decisions whilst women are expected to remain passive (Makhaye, 1998: 93; Shefer et al., 2005: 78). Furthermore, women cannot introduce condoms without the cooperation of men. As a result, Bujra argues that expecting women to initiate HIV preventative behaviour has proven to be futile (2000: 7, 20). Hence from 1995 this new school of thought moved from changing the behaviour of women, to changing the behaviour of men instead.

These academics, activists, policy makers, and people in the community running NGOs, argued that the best chance of protecting women was through men taking on HIV preventative behaviour, meaning that men had to be targeted by HIV prevention campaigns. Conference delegates at the time spoke of "men as partners", "male involvement", "caring masculinity", "men make a difference", etc. (Bujra, 2000: 9; Honig, 2007: 6, 13; Ruxton, 2004: 3, 217; Seidler, 2006: 173-176). It was suggested that successful interventions worked with both men and women and that gender needed to be reformulated to refer not only to women, but to mean the relationship between men and women (Bujra, 2000: 7). The meaning of Zulu masculinity at the time was one centred around risk-taking; it was believed that being a man meant to be fearless and strong. It was a masculinity that encouraged multiple partnerships (Shefer et al., 2005: 77). To stimulate HIV preventative behaviour this meaning

of masculinity had to be altered to include the concepts of responsibility and caring (Campbell, 2003; Honig, 2007: 13, 34; Mfecane et al., 2005: 99, 105; Ruxton, 2004: 8).

3.5.3.1 Bafana AIDS Project

The last section of this chapter describes in detail the ideology and approach of the 'Bafana AIDS Project', the second NGO at the centre of this thesis. Similar to 'Women and Children First', this NGO initially tried to tackle gender inequality through female empowerment. After failing to notice any improvements they changed their approach and turned their focus to male involvement instead. The 'Bafana AIDS Project' was founded by Khethiwe. She was born in 1956 as the daughter of the *induna* (community headman) of a rural area outside Pietermaritzburg. As her father's first child she had a special relationship with him. He did not raise her like most girl-children were raised in those days. Khethiwe helped her father with the cattle and instead of encouraging her to get married and be a mother, her father encouraged her to become a doctor and be independent. Khethiwe eventually trained to be a nurse and focused on community health. Together, father and daughter strived to improve general health in their community. They successfully lobbied for a health centre to be built on a piece of their family land that they donated to the community. During the early years of the HIV epidemic Khethiwe worked in a hospital in Pietermaritzburg. Here she treated people with AIDS related diseases, whilst the people in her community were still mainly unaware of the epidemic. After having seen many young women die in the prime of their lives, Khethiwe struggled to merely treat people when they were ill. She decided to get involved in HIV prevention instead. She gave up her stable job at the hospital and started her own NGO, the 'Bafana AIDS Project', in Pietermaritzburg in 1995. She educated women on HIV and its mode of transmission. She also empowered the women with skills to enable the implementation of this knowledge. Nevertheless she soon found out that when women tried to put their new knowledge into practice, they were confronted with resistance and even abuse from their male partners.

Khethiwe realised that women lacked control over sexual practice which made it impossible for them to implement HIV prevention. So in 1998 Khethiwe changed her tactics and started working on constructive engagement with men. She figured that if she could get the men to change risky behaviour, then women would indirectly be protected, which meant she would still achieve her initial goal. She started a project in which she trained amateur male soccer players in the age-group of fifteen to twenty as peer educators. These soccer players had a lot of symbolic capital in their communities. Khethiwe taught them how HIV is

transmitted, and what could be done to prevent transmission, like delaying sexual debut, avoiding sex when infected with an STD, avoiding multiple partners, and using a condom. She also taught them the importance of gender equality and that together with their female sexual partner they were responsible for HIV prevention. Finally, she provided the young men with strategies to deal with their peers who expected them to be well-informed on sex, to have multiple sexual partners, and to not be scared of risking HIV infection. Instead the soccer players became role models for a caring masculinity. Through role play, she taught them how to deliver HIV prevention messages to their friends, family, and members in their community. After completing the training she sent them out as peer educators.

In addition to the project with the soccer players, Khethiwe also set up a similar project with younger boys (nine to fourteen years old) in an attempt to reach them before their sexual debut. She started a project for orphaned children in which she paired them up with a "big brother". This way she supported orphans whilst at the same time promoting the concept of men as carers and positive fatherhood. She also designed a project that provided home based care for people in the community who were HIV positive. Finally she set up a project to empower community groups with particular skills. As part of this project she would for instance organise workshops in which she taught people how to talk to the youth about sexuality, how to grow vegetables, and how to apply for grants.

After setting up and running the NGO for almost fifteen years Khethiwe took a step back and handed the leadership over to one of her long-term operation managers. Under new management, the NGO changed its strategy and focused mainly on HIV counselling and testing, for which, at that stage, steady funding was available from the Department of Health. When I joined the NGO in 2010, mobile HIV counselling and testing was one of the few projects left. The NGO employed sixteen HIV pre and post-test counsellors in their twenties from the surrounding townships and rural areas. Half of them were Zulu men and the other half Zulu women. They had all started as volunteers for a small reimbursement, and after they had gained enough experience they were put on a salary. During my first visit it became clear that the NGO was struggling financially. At the end of 2010 funding for the 'Bafana AIDS Project' dried up completely and the staff members were made redundant. This was the end of the 'Bafana AIDS Project'.

Khethiwe, however, continued to design new projects. She has dedicated her life to community work, which has come at the cost of her marriage. She felt that she had been unable to fulfil her duties as a wife and therefore she divorced her husband. She bought her

own property which included a cattle farm. This reunited her with her childhood passion of taking care of cattle. It also allowed her to start a new NGO in which the farm played a central role. The farm served as an income generating project where she taught people both farming and business skills. Following the latest developments she also started a project that promoting medical male circumcision as an HIV prevention strategy. In 2010 I attended one of the first meetings she had with the local community leaders about medical male circumcision. She wanted to know what their thoughts were on circumcision and what needed to be in place for them to support a medical male circumcision campaign. Upon my return a year later Khethiwe's new NGO employed seven of the staff members that were made redundant at the 'Bafana AIDS Project'. They helped her promote and implement male circumcision at the local clinic. She needed these pre and post-test counsellors because HIV testing was part of the procedure prior to circumcision. Khethiwe's latest project was focused on female microbicide, a female controlled HIV prevention strategy. The gel had been tested and had shown to reduce the risk of HIV infection. Khethiwe was involved in lobbying for further testing and for making the gel publicly available.

Khethiwe is a versatile woman. She constantly thinks of new projects in line with the latest medical findings. The fact that she keeps up to date strengthens her funding applications. Being a member of the rural area she works in, Khethiwe understands the context in which people act and she knows where help is needed and wanted. When she designs a new project she involves community members to hear their opinion. The resulting projects suit local culture and get the support from the local community. Instead of perceiving the interventions as foreign the community takes ownership of them. By approaching the community instead of individuals, Khethiwe pushes for a collective change, which enables individuals to take on HIV preventative behaviour.

3.6 Conclusion

This chapter studied both early and more recent global, national, and local responses to the HIV epidemic. For the last thirty years policy makers have asked the question: how can an individual be motivated to implement HIV preventative behaviour? This chapter has criticised initial suggestions that individual awareness would lead to behaviour change. Criticism which is supported with arguments from chapter two stating that individual practice is not merely based on individual choice, but is also heavily impacted by structural factors. When this is applied to the implementation of HIV preventative practice, efforts should not be focused on

individual HIV awareness, but should instead focus on changing the collective perception in support of HIV prevention strategies.

Besides criticizing the early interventions for being solely focused on individual HIV awareness, this chapter has also criticised the early interventions for promoting condom use as the only solution. It is understandable that the initial HIV interventions that were brought to Africa resorted to the promotion of condom use, because it had been successful in reducing HIV transmission among the gay population in the west. However, the context of the HIV epidemic in South Africa was different and it soon became clear that condom use was not necessarily the best solution for this particular context.

The comparison between Botswana and Uganda's HIV intervention has shown how Botswana's HIV interventions, focused on individual HIV awareness and condom promotion, failed to result in behaviour change. Whereas Uganda's HIV interventions, focused on mass mobilisation and attending to locally inspired interventions, successfully reduced HIV transmission. Instead of individual HIV awareness, Uganda responded to the HIV epidemic by making HIV prevention a national crusade and transforming collective norms in a way that encouraged individuals to implement HIV preventative behaviour. Furthermore, instead of merely promoting condom use, Uganda's interventions focused on promoting a decline in multiple concurrent relationships and a delay in sexual debut.

Chapter seven of this thesis shows how, like Botswana, South Africa's initial HIV interventions focused on individual awareness and how condom promotion struggled to lead to behaviour change. This is followed by chapter eight which describes how in South Africa interventions such as HIV counselling and testing, medical male circumcision and virginity testing promoted through social mobilisation, with obvious political and civil support, and presented as culturally appropriate are more likely to lead to individual behaviour change.

Furthermore, this chapter has indicated how gender inequality is one structural factor restricting individuals from implementing HIV preventative behaviour. As a result of gender inequality women who have knowledge of HIV prevention might struggle to implement it. The description of the two NGOs at the centre of this thesis shows that both NGOs attempt to tackle the problem of gender inequality in order to enable HIV preventative behaviour. Whereas 'Women and Children First' aims to empower women to overcome gender inequality, the 'Bafana AIDS Project' aims to instil a caring masculinity which encourages men to adopt HIV preventative behaviour and consequently protect sexual partners. Both

NGOs realise that individual HIV awareness cannot lead to behaviour change as long as the structural factor of gender inequality impacts individual choice.

Chapter 4: Methodology

4.1 Introduction

This thesis is based on anthropological research in the classical sense; the research is conducted by an outsider from the west travelling to a 'non-western' society where the researcher then has a complete embodied experience in the attempt to gain an insider's perspective of this society. This is how anthropology started, but at the University of Canterbury and anthropology departments worldwide, this is no longer the only way in which anthropology 'is done'. More and more anthropologists do anthropology 'at home', studying their own country and some even their own community.

When I arrived as an outsider in a rural area of KwaZulu-Natal where I was the only white person I experienced a culture shock. During the first weeks all I could notice were the differences between 'their' society and my own. However, as time went on, I started to see what Goffman has referred to as "the familiar in the apparently strange" (as quoted in Hammersley & Atkinson, 1995: 207). This chapter openly discusses the interaction between the researcher and the researched that ultimately created the data that is used in this thesis. Malinowski stressed the importance of transparency. He argued that the researcher has to be open about how the information is gathered so that a comparison between different studies is possible (Malinowski, 1922: 3).

The start of this chapter sets the scene which allows the reader to envision the research setting. The previous chapter has already introduced the two NGOs at the core of this thesis. This only leaves Faras, the rural area in which the researcher stayed during large parts of the research, in need of an introduction. After setting the scene, the chapter introduces the data collection techniques that were used during this research. The first technique attended to is interviewing and it discusses both the benefits and the restrictions of this technique as experienced by the researcher. The second technique that is presented is participant observation. As part of this participant observation the researcher took on the role of a Zulu daughter whilst staying with a Zulu host-family. This section discusses the value this has added to the research. The third technique used in this research is informal conversations, which provided a different dynamic once again, complementing the other two strategies. Ethical considerations follow the discussion on the data collection techniques. This chapter finishes with a description of how the researcher analysed the gained data. This includes an introduction into the method of discourse analysis, which is used in chapter seven, and a

description of the researcher's personal biases which undoubtedly have affected, to a small or larger extent, both the material gained and the interpretation of this material.

Throughout the thesis when the term participant is used it refers to the community HIV educators from both 'Women and Children First' and the 'Bafana AIDS Project'. It also includes four independent community HIV educators from Faras. When information is used from anyone that is not a community HIV educator he or she will not be referred to as participant, instead it will be specified who they are: for instance a member of the host-family, a neighbour, a member of the virginity testing group, etc.

4.2 Introducing the research setting

The seed of this thesis was planted during my Master's thesis research in 2007, when I first met the group of female community HIV educators working at 'Women and Children First'. Despite not playing the leading part in the Master's thesis, which had a child-centred focus, I spoke to these women at great length. Their stories about gender relations and limitations to implementing HIV prevention had me fascinated. I decided then that I needed to come back to record their stories. Before I went back to these women I delved into the existing literature, to establish in what way their stories could be told and analysed, so that they would contribute a new element to the existing literature. I decided on studying the willingness and ability of these community HIV educators to negotiate HIV prevention in their everyday intimate relationships. Of these community HIV educators it could be stated from the outset that they are well-informed about HIV prevention and, depending on the specific NGO they worked for, they have been at the receiving end of either 'female empowerment' or 'responsible masculinity' programmes. This was important because, as chapter three has shown when it discussed the social cognition models, for a long time individual awareness has been held as the main requirement for individuals to implement HIV prevention. It soon became clear that a thesis about gender relations and HIV prevention would be more valuable when it not only attended to the female, but also to the male perspective. This initiated a search for a group of male community HIV educators, which I found through the NGO the 'Bafana AIDS Project'. The directors of both NGOs gave me permission to come over and spend time with their staff. The first period of fieldwork was from February until July 2010 and the second period of fieldwork was from June until November 2011. This thesis is based on my interaction with ten community HIV educators from 'Women and Children First', sixteen from the 'Bafana AIDS Project', and four more whom I met whilst living in Faras.

Figure 10: Map of the world highlighting South Africa
(Geology, 2014)

Figure 11: Map of South Africa highlighting KwaZulu-Natal
(Wikipedia, 2014b)

Figure 12: Map of KwaZulu-Natal highlighting eThekwini municipality
(Wikipedia, 2014a)

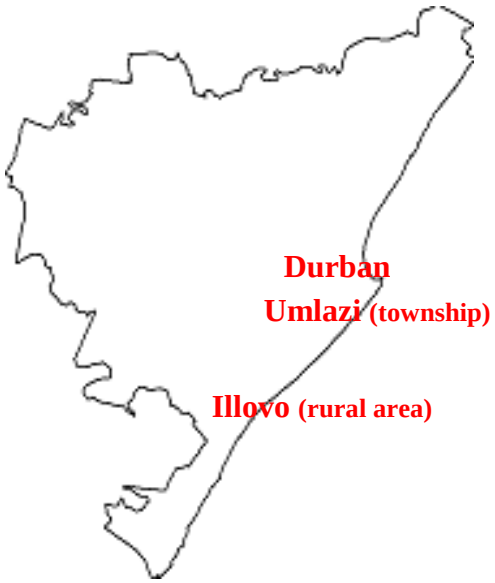

Figure 13: Map of eThekwini municipality identifying the area in which 'Women and Children First' is active
(By: E. Maureau)

Figure 14: Map of KwaZulu-Natal highlighting Msunduzi municipality
(Wikipedia, 2014c)

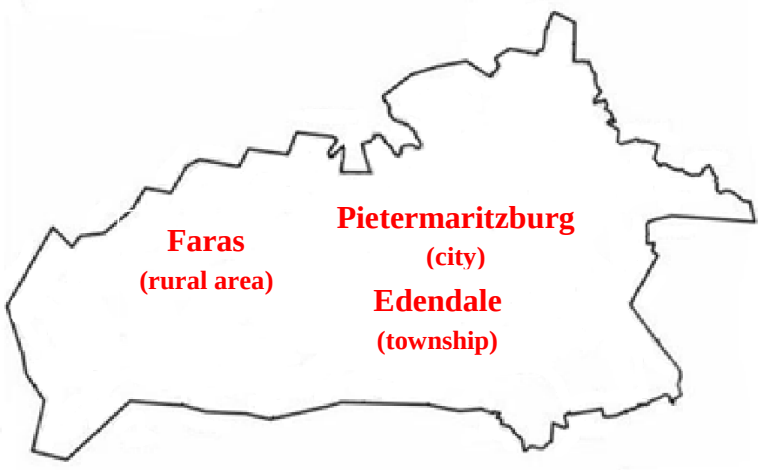

Figure 15: Map of Msunduzi municipality identifying Faras and the area in which the 'Bafana AIDS Project' is active
(By: E. Maureau)

During my first visit to the 'Bafana AIDS Project', I noticed a picture on the wall of a white man my age in a rural Zulu setting. This turned out to be an American who had lived with a host-family in Faras for a year. I explained that this was exactly what I was hoping to do, after which Mqondisi suggested I should meet family Ndlela. When I went to meet the Ndlelas in Faras for the first time they were surprised to see that I was a woman. Although the stay of the American had gotten the community used to the idea that white people were interested in spending time in Faras, a white woman staying in the community was unheard of. I explained to the family that the purpose of my stay was to learn about their way of living and therefore I was hoping to participate as a member of their family (e.g. sharing the meals with them, helping them with chores, and joining them on family occasions). Family Ndlela agreed to host me.

Located in the foothills of the Drakensberg, 100 kilometres west of Durban, is the rural community I came to live in, which I refer to as Faras. This place gets hot in summer, but in winter a dusting of snow is not uncommon. The nearest city is Pietermaritzburg, which is where the majority of the people from Faras work, study, or do their shopping. To get there most people took a minibus taxi which cost eighteen ZAR and took about 40 minutes.[17] A small minority travelled by bus, which worked out cheaper when used regularly, but was less flexible. Only two roads in Faras were sealed, the rest of the roads were gravel. Taxis had to drive slowly on these gravel roads, but the buses drove fast, and left a trail of dust when they passed. This red dust symbolized the rural area, because the roads in town or in the townships were all sealed. Before commuters from Faras reached town, they dusted of their shoes and made them shine just like the shoes of the people living in town or in the townships. Over winter the hills were dry and the roads were particularly dusty, but in spring the hills turned green and the dusty roads changed into muddy tracks. This mud was just as detested as the dust.

[17] When the participants talked about distances they rarely described this in time or in kilometers, instead they described a distance in the price of the taxi. Eighteen ZAR is considered a big distance from Pietermaritzburg.

Figure 16: Photo of a dry winter scene
(By: E Maureau 2010)

Figure 17: Photo of a bus driving on a gravel road in the early morning, leaving a trace of dust
(By: E Maureau 2010)

Figure 18: Photo of a green spring scene
(By: E Maureau 2011)

According to the inhabitants of Faras, advantages of living in the rural area, as opposed to the township, were the higher level of safety as a result of social control. It was also cheaper to live there because people do not have to pay rent or rates. Furthermore, in the rural areas the properties were a lot bigger as they were spread out over a bigger area, which allowed people to grow vegetables, keep animals, and build their own houses from the soil on their properties. Besides the mud and the dust the disadvantage of living in the rural area, as opposed to living in the township, was that there were only a few jobs available in the rural area and the commute to Pietermaritzburg was expensive. As a result the rate of unemployment was high. This meant that many families depended on state pension money and child benefit to make ends meet. Furthermore, there were fewer facilities (e.g. health care, education, emergency services) in the rural areas. There was a clinic in Faras, but the nearest hospital was a forty minute taxi ride away and the nearest police station was a thirty minute taxi ride away. When calling the emergency number it could take an hour before an ambulance would get to Faras and half an hour before the police arrived. Although according to some of the residents of Faras, they often did not come at all, so in case of an emergency people were more likely to look for a community member with a car to drive the patient to the hospital. Faras had three primary schools and one secondary school, but these schools were not highly regarded. This meant that those parents who could afford it would sent their children to a private school half an hour away.

Mister Ndlela had a good job as a manager in a furniture shop. The city he worked in was three hours away, so he would only come home for the weekend. On the property of my host-family stood several rectangular buildings. Together with his wife, son, and daughter, Mr Ndlela lived in the first building. It was a relatively fancy house with indoor plumbing, tiling, electric appliances in the kitchen, and fancy furniture throughout the house. The second building, which consisted of two bedrooms and a bathroom, was built to rent out. I shared this building with a contractor from Vrijheid who was in Faras to seal one of the gravel roads. The bathroom had a shower and a flushing toilet, a luxury that was rare in the rural area. All our direct neighbours only had one running tap which was outside in the middle of their properties. The third building on the property was set up as an *isitolo* (shop). The fourth building was a garage for the car Mr Ndlela owned. He was one of the few people in the neighbourhood who had a car. The garage also functioned as a gym with several fitness machines and weights. My host-brother frequented the gym often and his mates joined him

for a small 'membership' fee. The *isotolo*, the rental property and the gym membership highlight the commercial mindset of this family. The fifth building on the property was round and was called a *rondavel*. 'Traditionally' the *rondavel* was used to worship ancestors; however my host-family were strict Christians who disapproved of ancestor worshipping. Instead they used the *rondavel* when the church members came to visit. There were three church buildings in Faras; a Roman Catholic church, a new independent church, and a Wesleyan church. Other denominations used schools and community halls for their services and the Shembe independent church had their service outside. The last building on the property was a small construction that housed the longdrop toilet, which was only used when the water was disconnected. For those occasions the family also had a big water tank on the property. Generally houses in Faras were built by the families themselves. The bricks were made out of dirt and water and they were baked in the sun. The roofs were made out of corrugated iron. The walls were plastered and then finished off with a layer of paint. All the buildings on the property were painted in the same colours. This was done in two layers; a darker colour on the first fifty centimetres of the bottom and then a lighter colour on the rest of the building, see Figure 16. Only the richer people could afford to buy bricks or even pay someone to build a house for them. Up until recently there were no RDP houses (Reconstruction and Development Programme; low cost government housing) in Faras, but in 2011 government agencies had started building a few of these long awaited houses. Many families kept chickens and roosters on their properties. Some families had a dog, but the majority of people in Faras seemed apprehensive of dogs. On the open fields between the properties cattle and goats grazed. Many households also had a vegetable garden. People generally kept the little they had in good condition. Their houses were clean, their clothes were ironed, their shoes were polished, and their gardens were tidy.

4.3 Data collection techniques

Ultimately I wanted to talk to the participants about the implementation of HIV prevention strategies in sexual relationships. To do so I had to establish the kind of relationship in which participants felt comfortable talking to me about sex. I anticipated that this was going to be the crux of my study, as I expected that sexuality was going to be a sensitive topic to talk about. Prior to the first period of fieldwork I explored different techniques to discuss sexuality with participants and I decided not to bring up the topic on the first meeting, nor would I do so during a formal interview. Instead I planned to establish a trusting relationship prior to cautiously bringing up the topic of sexuality. After all of this careful consideration I was

surprised to find the participants openly discussing sexuality in my presence soon after I had arrived. This led me to adjust my expectations only to be caught out again after bringing up the topic of sexuality too easily in places where this apparently was considered inappropriate. Gradually I was able to identify where the boundaries lay regarding the suitability of the topic. These unwritten boundaries had me 'dazzled' throughout the fieldwork. According to Strathern this is often a sign that the researcher has stumbled upon important material (1999: 11). Throughout the research the boundaries around the suitability of discussing sexuality played a central role. I used interviews, participant observation and informal conversations to gain different levels of data. Ultimately I came to an in depth understanding of the different settings in which the participants could and could not speak about sexuality. This proved to be an invaluable insight when it came to understanding the barriers to negotiating HIV prevention. The following discusses these different data collection techniques and their significance.

4.3.1 Interviewing

The first data collection technique I used was interviewing. The interviews were semi-structured; instead of using set questions, I prepared a list of topics that I wanted to discuss with the participants which enabled the interviews to flow like a conversation. I wanted the participants to speak freely, to see what they were willing to share (J. Green & Thorogood, 2005: 80). Once they started to share, I encouraged this by asking related questions. If I could no longer see the relevance I returned to my list of topics and introduced a new topic to the conversation.

With some of the more talkative participants the interviews turned into the participant narrating their life stories to me. Some of these life stories are recounted throughout this thesis as they give insights into where the participants are coming from and how structural factors have affected their individual lives (J. Green & Thorogood, 2005: 38). This technique was also used by Farmer (1999) in his book titled 'infections and inequalities'. As Farmer discussed certain issues, he added case studies to give the reader an impression of how these issues affected individuals in their daily lives. By using this method he makes significant issues come to life.

I interviewed participants at both the beginning and the end of my stay. In the beginning the interviews functioned as a tool to get to know the participants. At the end, the interviews functioned as a last chance to have a focused private conversation about behaviour I had observed. The setting of the interviews changed according to the location. At 'Women and

Children First' the interviews took place at the centre. Here I had access to a counselling room to conduct the interview. At the 'Bafana AIDS Project' the participants were always travelling around the area with a mobile testing set-up operating out of canopy tents. I interviewed the participants in these tents, or in the mini-van that was driving us from location to location. Some participants were that busy that they were hard to pin down for an interview. In this case I had to find moments in their day in which they could not do anything else. For example, I interviewed Nomsa in the back of a *bakkie* (pick-up truck), which was taking her from the one meeting to the next. Whilst struggling with my car sickness, I had my one chance to ask what I had been wanting to ask her for a long time.

Compared to the other data collection techniques discussed below, the interviews generally had a formal feeling to them, partly because it required an appointment. Furthermore, during the interview it was only the participant and me behind a closed door, be that the doorway of a room, a car, or a tent. Another formal element was that during the interview I had my topic list in front of me whilst holding a pen and a notepad.

All of this initially took away the spontaneity of the conversation as it reminded the participants that I was there as the researcher and that they were the ones being researched. It made them turn on their professional personas, that of HIV educators, which often resulted in the participants giving ideal-type answers, instead of talking about personal experiences. Some of the participants even hesitated to sit down for an interview. The idea alone made them nervous and caused them to keep postponing the appointment. Amukelani, for example, was reluctant because she felt that she had nothing important to tell. She did not consider herself a cultural specialist, which is what she thought I was looking for. In this case it was more the anticipation than the actual interview that gave stress. There were, however, also some participants who were nervous throughout the interview. Their brief answers gave me the feeling that they wanted to get the interview over with as quickly as possible. This feeling was confirmed later on in the research when Thabo told me how he and some of the others had experienced the first interview when I had just arrived at the research site. He recalled being very nervous to the extent that he was shaking. The participants secretly asked each other what questions I had asked during the interview. Nevertheless, most of the interviews started to flow after the first few questions, when the participants started to relax after they realised it was just a conversation and there were no wrong answers or direct personal questions.

After reading the work of Spronk, who did research on sexuality among young professionals in Nairobi, I decided not to audio-record the interviews. Spronk stopped recording after the first few interviews when she realised that the presence of the tape recorder caused people to hold back (Spronk, 2006: 32). Instead of the recorder I noted down keywords during the interview, which I then turned into a summary immediately after the interview. For most of the participants this style of interviewing worked well and after their initial hesitation they spoke freely.

The formal character of the interview was not necessarily a bad thing. Official interviews were expected as part of my role as researcher. Therefore they were taken seriously by the management of the NGOs. During these interviews we did not get interrupted. This allowed for quality time in which a topic could be discussed in great detail, whereas during informal conversations the topic of the conversation would change often. Furthermore, the official character of the interview unleashed the narrator in some of the participants. Without being distracted and having me as a patient listener, they had time to reflect on matters they may not often have reflected on previously. Most importantly, due to its official and professional character, interviews were the only appropriate time to discuss HIV/AIDS. I had come to find out that although these participants worked in the field of HIV and were able to discuss this matter freely in their role as community HIV educators, outside their professional role the topic was taboo. Although the participants often chatted about related topics, e.g. sexuality and relationship issues, it was rare for AIDS to come up during chitchat. The participants never brought up stories about, for instance, a friend, a neighbour, or a family member affected by the virus. Hence these interviews were my only opportunity to ask the participants questions about HIV and AIDS.

4.3.2 Participant observation

In this section I will argue for the value that participant observation adds to anthropological research. I believe that participant observation complements what can be achieved during interviews. Instead of rapid appraisal research, I argue (just like Malinowski and Evans-Pritchard did during the early years of anthropology) for a much longer period of research in which the researcher does not only use questionnaires and interviews, but also uses participant observation. Preferably a long period of time is spent getting to know the participants. During this time ideally the anthropologist lives amongst the participants whilst experiencing their way of life, eating what they eat, doing what they do, talking about the things they talk about (Evans-Pritchard, 1976 [1937]: 243; Malinowski, 1922: 6). Evans-

Pritchard explained: "I found it useful if I wanted to understand how and why Africans are doing certain things to do them myself" (Evans-Pritchard, 1976 [1937]: 243). This way the researcher starts to live, think and feel as a member of that culture (Evans-Pritchard, 1951: 78, 79) and is therefore no longer interpreting behaviour from his own ethnocentric perspective, but instead is able to, as Malinowski puts it, "grasp the native point of view" (1922: 25). By spending time with the participants outside the interviews I tried to achieve a more holistic, 'deeper level of understanding' (Kondo, 1990: 23), especially of the context in which ultimately sexual negotiation takes place. This is important because "it is impossible to understand clearly and comprehensively any part of a people's social life except in the full context of their social life as a whole" (Evans-Pritchard, 1951: 80).

Although I gathered interesting information through interviews, the foundation of this thesis is based on the data gained through participant observation. My participant observation consisted of several layers. I gradually immersed myself in the daily lives of the participants. It started by spending the working day with the participants. I travelled with them to their work location and helped them with their tasks whenever that was possible. The moments there were no clients there was time to sit around and chat casually. The next layer of participant observation was added when I moved in with a Zulu family in a rural area. Compared to staying in a backpacker's hostel in town, this allowed me to come closer to experiencing daily life the way the participants experienced it. Just like the participants I now had to get up early each day to get ready to travel on the taxi to work, I ate *phuthu* (thick maizemeal porridge), *samp* (dried corn kernels) and beans, and *jeqe* (steambread), I watched the popular TV show, 'Generations', I worried about thunderstorms, and I spend the whole morning of my day off washing my clothes by hand. Furthermore, I was able to observe the interaction between men and women in a Zulu household. The final layer of participant observation was added when I visited and stayed with some participants at their family homes. This gave me an insight into their specific living conditions; who they lived with, who depended on their income, how they interacted with their family members, and what they did on their days off. These visits were invaluable. It added significant depth to the data I had already gained.

4.3.2.1 Immersion

Upon moving in with my host-family in Faras I took on the role of adoptive daughter, just like Kondo (1990) and Abu-Lughod (1986) had done in other contexts. To express my respect I never addressed my host-parents by their names; instead I addressed my host-father as *Baba*

and my host-mother as *Mam*. However with my siblings, who were younger than me, I alternated between their names and calling them *bhuti* or *bhut* (brother) and *sisi* or *sis* (sister). Whilst living in the host-family I learned about the way of life in Faras. By taking on the role as daughter I was "living in a social world defined by the same boundaries as those experienced by members of the community [this] allowed me to grasp more immediately just how the social world worked and how its members understood it" (Abu-Lughod, 1986: 22). This experience went from sharing a bed with my host-sister[18], to being woken up early by the roosters crowing and the birds tapping on the corrugated iron roof. For weeks, whilst I was still waking up, some neighbour would turn on the stereo to play the song Loliwe by Zahara, on repeat. At any moment of the day visitors would walk into my room to check what I was doing. My host-father spoke to me about family politics and my host-mother taught me how to cook Zulu dishes. They invited me to church, wedding ceremonies, and family visits. I was taught how to hand wash my clothes by my host-sister, and my host-brother taught me about the Zulu language. My host-uncles proved to be very patient when they talked me through family rituals, like the marriage protocol and the process of face-scarification.

From living with this family I also learned about *hlonipha*, how to express respect to parents, community elders, men, and guests. I was taught how to shake someone's hand and how to receive or give something. I became aware of the importance of avoiding eye contact and sitting down lower than, or even kneeling down for, the person one is expressing respect to. I realised that it was best to wear skirts instead of trousers and in certain situations to even cover my hair with a *doek* (headcloth). I also learned how to serve people respectfully using a tray and who to serve first in different situations. I was introduced to the concept of *phelezela* (escort or accompany): when guests leave it is polite to not only walk them to the door, but also to escort them off the property, and to accompany them for a certain distance towards their home. I also learned to be patient when greeting people. It often happened that people on the street would wait to say hello until after we had passed each other. Initially I interpreted people's lack of immediate greeting as disinterest or even arrogance, only to find out later it

[18] After saying goodnight the first night my host-sister followed me to my room in her pyjamas. Apparently she was sleeping in my bed. This was not something that had been spoken about. She explained that *Mam* worried I would be too scared to sleep by myself. It was very thoughtful, but I was actually quite happy to have at least one moment in the day to be by myself. I did not tell my host-family. However, after a week my host sister got the flu and was told not to sleep in my bed for a fear that she would pass it on to me. As of that moment it became clear to everyone that I was alright with sleeping by myself.

was a sign of respect. I had to learn not to fill what I experienced as awkward silences or the moments of uncertainty, not to speak too soon, but to keep quiet and wait and see instead.

Living with the host-family I learned that this element of Zulu culture (the patience and the remaining quiet to express respect) also played a large role in the relationship between men and women. When I first joined my host-family, *Baba* had a good job as a manager in a furniture business, *Mam* ran an *isitolo* on the property, and the children attended a private school. However, during my second visit my *Baba* had quit his job as a result of his diabetes. He was at home whilst my *Mam* had started working as a window-cleaner in town. At times I felt sorry for my *Mam*. I observed how *Baba* was perfectly capable of looking after himself during the day; cooking lunch and making his own tea. However, as soon as *Mam* returned home after a long day of work he expected her to make him a cup of tea whilst he was sitting on the couch watching TV. According to the usual division of labour it was normal for the woman to look after the domestic chores, whilst the man was providing for his family financially. However, in this case *Mam* had been out all day providing financially for her family, whilst *Baba* had done very little. Yet still she had to do the domestic chores when she arrived home. I found that on the odd occasion *Baba* would contribute to the chores by doing a load of washing or doing some preparations for the evening meal. However, all his efforts would take place when *Mam* was away. As soon as she arrived, he expected her to treat him with the respect he felt he deserved. It seemed as if he found it even more important to have his position as the head of the household reaffirmed, now that he was no longer financially providing for his family, as if to settle his insecurity.

In the beginning I struggled not to speak my mind. The way *Baba* expected to be treated went against the core of my being when I related it to the relationship I had with my partner. I had to bite my tongue not to tell *Baba* to get off his lazy backside and use the hands God gave him to make his own cup of tea and maybe one for *Mam* as well now that he was up anyway (a literal Dutch translation of a typical response to express discontent to situations similar to this one). I realized that if I would have said this out loud, I would have expressed extreme disrespect to *Baba* and his family who had been wonderful hosts to me. Furthermore, I was not supposed to experience and judge their interaction from my perspective. Instead I was supposed to understand it from an emic perspective. So I tried my hardest to be respectful like *Mam*; to transition into my Zulu 'persona' and push my Dutch identity to the background (Kondo, 1990: 12,15,16). As a compromise I jumped in to make *Baba*'s cup of tea when *Mam* came home from work, so that *Mam* could sit down and relax for a moment.

At the end of my first stay with 'Women and Children First' in 2007 I was given the Zulu name Lungile, which can be translated as 'she is alright'. When I arrived at the 'Bafana AIDS Project' we talked about this name and the participants decided from that moment onwards to refer to me by my Zulu name and they added the surname of my host-family. In Faras hardly anyone knew my Dutch name. As of that moment my identity as Eva Maureau gradually faded away and I became Lungile Ndlela. Having this name turned out to be helpful in many ways. First, similar to Reader (1966), I experienced that these fictitious kinship ties were often taken semi-seriously and as such opened many doors not just with relatives of my host-family, but anyone called Ndlela. Any Ndlela was introduced to me as my brother or sister. I was told it does not matter where I was in South Africa, a Ndlela would always look after his or her 'sister'. Second and more importantly, having a different name aided my transformation. As Lungile it was easier to distance myself and my opinion and to take on the role of a respectful Zulu daughter. As a woman raised in a western society, or maybe because I am Dutch, or maybe because I was raised by my particular parents, I have always had very little patience for sexism and have often spoken out or shown resistance whenever I came across it. Not in Faras, there I was Lungile, and as Lungile I would free the couch when *Baba* walked into the living room and hand him the remote control. I would drop whatever I was doing when *Baba* demanded a cup of tea and I would not even blink when he would send me back to get him his favourite saucer or teaspoon. Evans-Pritchard was often asked if he, when among the Azande, started to belief in witchcraft. His answer rings true for how I felt regarding the gender relationships: "In my own culture, in the climate of thought I was born into and brought up in and have been conditioned by, I rejected, and reject, Zande notions of witchcraft. In their culture, in the set of ideas I then lived in, I accepted them" (Evans-Pritchard, 1976 [1937]: 244).

As a result of participant observation I gained a better understanding of the social fabric. Having this insight enabled me to understand why my participants made the decisions they made. By not just observing, but also experiencing their way of living, I could see that certain decisions made sense in this particular context. I started to experience the behaviour of the participants as less foreign and I was able to relate to them. I gradually became immersed in Zulu society. I lived in a Zulu homestead, ate Zulu food, attended and participated in Zulu ceremonies, I had started to dress like a Zulu woman, and I took on Zulu mannerisms. Malinowski advised anthropologists not to live with people of their own culture during their fieldwork (Malinowski, 1922: 6) and to some extent I was cut off from my own culture. I was

the only white woman living in Faras and due to a lack of internet access in Faras I was hardly in contact with my family, friends, and supervisors back home. As such I had become dependent on my host family and participants for safety, information, and entertainment. I had transitioned into my role as Zulu daughter and I came as close as possible to seeing life through the eyes of my participants, the "natives' point of view" (Evans-Pritchard, 1951: 79, 80). Although my experience was far less remote than that of Malinowski and Evans-Pritchard in the early 20th century (I had a mobile phone, visited an internet cafe on trips to the city, watched American movies on TV, and bought European food at the supermarket) I had become deeply immersed into Zulu life in a rural area in KwaZulu-Natal anno 2010/2011.

According to Malinowski being around the participants at all times for a long time results in the anthropologist no longer impacting on 'native' life and conversations:

> as the natives saw me constantly every day, they ceased to be interested or alarmed, or made self-conscious by my presence, and I ceased to be a disturbing element in the tribal life which I was to study, altering it by my very approach, as always happened with a new-comer to every savage community (Malinowski, 1922: 8).

Although I do not believe that over time the researcher ceases to influence the behaviour and information presented by the participants, I do agree with Eriksen that over time the researcher will be less noticed as an outsider and therefore life and conversations will continue more as usual (2001: 26). Although I was forever standing out as the *umlungu* (white person), I had blended in to the extent that I had become less of a spectacle. Over time I was included as someone who could be trusted with information because I had learned to express respect appropriately. It was only when my two worlds collided that I was confused as to what role to play. One day after returning from a wedding in Zululand, one of the participants accompanied me to a large mall to print off the photos I had taken of the wedding. The photos were developed by two young white males. These photos were taken by me, who after a period of immersion had been given access to this deep Zulu occasion and was able to understand its meaning. Now these photo developers were confronted with deep Zulu images of which they could not comprehend the meaning. Their response was disrespectful. Both the participant and I noticed that they ridiculed the photos. I could understand their lack of understanding, but I also felt deeply offended. Like Turner's

description, I felt "betwixt and between" two cultures (V. Turner, 1967: 97). I was living in two different worlds at the same time, becoming "a sort of double marginal [wo]man, alienated from both worlds" (Evans-Pritchard, 1976 [1937]: 243). My loyalty was with the participant, but I imagined how both parties felt that I came from the same world as these photo developers, and that ultimately this would be the world I would go back to. Thinking of Evans-Pritchard's words: "in any case one always remains oneself, inwardly a member of one's own society and a sojourner in a strange land" (1976 [1937]: 243). I worried that the participant regretted letting me into his world. It was that moment that I realised the magnitude of the task ahead of me, of writing a thesis in which I would introduce the participants to my readers. I may have been able to understand what I had seen, but this was after months in the field. How would I compile a thesis in such a way that I could make the reader understand what I had seen and experienced? I was only partly comforted when I read Strathern's work who wrote that this is something that many anthropologists struggle with (1999: 1).

4.3.2.2 The significance of participant observation

In my opinion compared to a distant and dominant interview, participant observation is more likely to establish trust among the participants. Over time the participants feel that the researcher is able to understand and will be respectful with sensitive information, they feel the researcher cares about them, and they feel that their relationship with the researcher is more like a friendship. This results in the participants 'opening up' to the researcher. What can explain this difference?

First, it is common for participant observation to take place over a relatively long period of time. This means that there is plenty of time for the researcher and the participants to build rapport (J. Green & Thorogood, 2005: 62). There is time to get used to each other and to get to know one another. So much so that the formal relationship of researcher and participant is likely to transform into a more casual relationship, like a friendship. In this kind of relationship there is room for a two-way interaction. Hence the researcher is not always the only one asking the questions. Early on in my research I was driving home with the 'Bafana AIDS Project' team one late afternoon. It started to get dark and I was sitting in the back of the van with Thabo. He started to ask me questions about my family, my friends, my first boyfriend, my first kiss, the first time I had sex, the number of sex partners I have had, and the expectations I had of a relationship. I decided to openly answer his personal questions as I felt it was only fair that if I expected the participants to share personal information with me, I

would have to share with them too. Furthermore, if I showed the participants that I trusted them with my personal information, they might feel that they could trust me too. After I had answered Thabo's questions he automatically started talking about himself; his first girlfriend, the time he caught his girlfriend cheating on him, and having a child with a girl he was only casually seeing. Being open myself clearly led to him being open as well. The fact that I had trusted Thabo enough to answer his questions had made him feel special. It turned out to be the start of a friendship in which he has been willing to answer many personal questions and in which he has been updating me on his love life without me even asking about it.

Another reason why in my opinion the method of participant observation encourages participants to 'open up' is that good understanding has the potential of being rewarded with a deeper level of information. The more time one spends in the research field, the more the researcher starts to pick up. Researchers only see the things that have meaning to them. Once researchers are aware of something, they will see it in what happens around them. As researchers get a better understanding, their questions will become more relevant. Living in Faras I had learned about ways to express respect, like wearing skirts instead of trousers. I did not think it mattered much if I followed these guidelines or not, because people were friendly to me irrespectively. They never told me off when I was wearing jeans. Only later I came to realise how much it was appreciated when I did follow the guidelines. My participants had closely watched my transition. They observed how I slowly changed my style of dress, the way I talked, and the way I approached people. From my behaviour and the questions I asked it became obvious to the participants that I was starting to understand their way of living. They could see I was ready for what the participants themselves referred to as 'deep Zulu'. Instead of giving me the short simplified version, they started to explain both Zulu 'traditions' and personal stories in more detail. They gave me access to the insider's perspective. This explains why only during my third visit, Sibongile took me to her family's rural homestead for a wedding. This time around she knew I was ready; that I would behave appropriately and that I was able to understand what was going on. Hence, by expressing my respect in the 'traditional' way, including wearing skirts instead of jeans seemingly unimportant at the time, I ultimately gained more access.

A third reason why I believe the method of participant observation is more likely to result in participants opening up is because the participants are more likely to be under the impression that the researcher cares about them. The first time I met the participants from

‘Women and Children First’ was in 2007 when I was there for three months to conduct research for my Master’s thesis. When I came back in 2010 to conduct research for this thesis, the participants already knew me. To them my return indicated that I was truly interested. Merely by returning in 2010, a layer of trust was added to the already well-established relationship. This effect was even stronger when I turned up again the year after that. By then I was practically considered ‘part of the furniture’, the participants told me. Making contact with the ‘Bafana AIDS Project’ was different. I did not know anyone there, but via email they had agreed to host me for a couple of months. Sibongile and Thulani from ‘Women and Children First’ accompanied me on my first visit to the ‘Bafana AIDS Project’. Having them there proved to be invaluable. I was practically ‘handed over’ with a good reference from the one group of participants to the next. Sibongile introduced me as a good person who wanted to learn about Zulu culture and HIV/AIDS. Had I gone to the meeting by myself I would not have been able to establish the same mutual sentiment. The next months I worked hard on getting to know everyone and establishing good working relationships. Similar to my experience with the participants at ‘Women and Children First’, my return to the ‘Bafana AIDS Project’ the following year contributed significantly to the level of trust, intimacy and comfort there was between myself and the participants. I felt that each time I returned the level of information thickened. For this reason I would suggest that the bulk of data used in this thesis comes from the last research period in 2011, the final months of fieldwork being the most productive. This does not mean that I had been wasting time in 2007 and 2010. According to Kondo this had been a period of ‘laying groundwork’ (1990: 23). In those years I learned how to behave respectfully whilst also building relationships with the participants, which eventually led to them opening up to me in 2011.

The final reason why participant observation has the tendency to make participants feel comfortable ‘opening up’ to the researcher is because participant observation is a levelling experience. It encourages a process in which the participants can feel equal, or even superior to the researcher. Participant observation has the tendency to bring out the teacher in people; it makes them feel they have something to offer. Central to participant observation is participation in the daily lives of the participants. Many anthropologists position themselves as apprentices who are there to learn from the experts. For instance Locke (2007) was taught how to handle an elephant by his Nepalese participants, Lee (2012) was taught by the !Kung how to hunt, and Moeran (1998) was taught how to be a respectful Sake drinking companion by his Japanese participants. Instead of positioning themselves as superior foreign researchers

they undid the set hierarchy by presenting themselves as knowing very little about the subject that the participants have specialised in. This levelled their relationship.

I tried to achieve the same thing, but as a white researcher in South Africa it was not easy to overcome the set hierarchy. The interaction between a white and a black person in South Africa is coloured by layers of history. I found that during our initial contact many participants treated me with a respect that I had not earned by anything, but by my white skin colour. In my interaction with the participants I worked hard to break down this classic hierarchy. My intention was to create a relationship in which they felt comfortable telling me when I was wrong, and when they did not want to do something, or did not want to answer a particular question. I wanted to create a relationship in which I was not perceived as the 'master' but the 'pupil' (Evans-Pritchard, 1951: 80). Ideally they would see me as their apprentice; they had the knowledge and I wanted to learn from them.

The following example shows one of the slightly uncomfortable but invaluable moments, which made the participants realise that I was merely a 'clown' and that they were the experts (Eriksen, 2001: 24). As previously mentioned, at my host-family I had a running shower. However, none of the participants I stayed with on various occasions had this luxury. Instead I was given a bowl of warm water to wash myself with. Up until my visit to Cebisile's house I had managed to improvise in private. However, the day that Cebisile passed me the bowl with warm water she stayed in the room. Conscious of my nakedness and unaware of the proper way to use the bowl, I tried to wash myself. Whilst getting half undressed I kneeled down in front of the bowl washing the upper half of my body. The water was splashing all over the floor. I then moved on to the lower half of my body. Up to that moment Cebisile had been patient, but now she could no longer hold her laughter. She told me that she was sorry that I did not know how to wash myself using the 'African bowl'. She brought in another bowl of water for herself and showed me how it was done. She fully undressed and stepped into the little bowl. She crouched down, put soap on a cloth and washed her whole body, hardly spilling any water on the floor. She had just instructed an adult woman how to wash herself. That moment it became clear to her that there were many things I did not know and that she could teach me. It 'validated' her as 'knowledgeable' (Leclerc-Madlala, 1999: 12). My apprenticeship was not limited to practical matters like washing, cooking, ironing, and beer brewing, but also transferred to knowledge about how best to use your female charms to get men to do things for you, how to keep your boyfriend sexually satisfied, how to hide being proposed to by more than one man, etc. It became clear to the participants that although

I was the one who had gone to university, there were many things I did not know about, but they did. I had proven to be a keen student and they took on the role as teachers.

Another significance of participant observation is that it can also be used as a double check to validate information. During long periods of participant observation the researcher can pick up on discrepancies between what the participants 'say they do, and what they actually do' (Malinowski, 1922). For instance condoms are central to this thesis. They have been heavily promoted by international HIV interventions and by the NGOs the participants work for. During my initial interviews the participants confirmed the importance of the use of condoms and suggested that they themselves used them. Had I stopped the research after these interviews I would have written a thesis that confirmed the use of condoms amongst this research group. It was not until I used the method of participant observation that I became aware of another side to this story. Obviously I was not observing the participants in the heat of the moment when they either were or were not using a condom. However, due to participant observation I learned, for instance, about pregnancies that had remained unspoken about in the interviews. When I asked the participants to explain these inconsistencies I was given access to a second layer of information. The participants explained how they struggled with the use of condoms, whilst also speaking about alternative strategies to reduce the risk of HIV transmission. By moving beyond interviews and spending a considerable time with the participants I reached a stage where they trusted me even with potentially unfavourable information. As a result this thesis is completely different from the one I would have written after only the first few months of the research.

4.3.3 Informal conversations

The third data collection technique I used was informal conversations. Instead of bringing up sensitive topics during a formal interview, informal conversations happened 'fortuitously' in the field, which led to data being gathered 'opportunistically' whilst casually spending time with the participants (J. Green & Thorogood, 2005: 80). Instead of the researcher controlling the topic of the conversation, as is common in interviews, these informal conversations were all about finding out what the participants found worthwhile talking about. This was very important for keeping an open mind in the study. The conversations started naturally. Often a topic came up as a result of something that happened in our surroundings, for instance when watching a discussion about cheating in a TV show, when seeing two people walking by holding hands, or when being handed a brochure advertising a 'traditional' healer who could increase sexual libido. These were great conversation starters about relationships and sex.

By spending long periods of time with the participants, I also had a good chance of being present when critical events took place, for instance when I attended a wedding I was talked through all the ceremonies it involved. The same happened when I went to visit a new-born baby and the mother started telling me, for example, about what was expected of the father. I also attended a graduation of the youngest daughter of a family. It was on this occasion that I learned that all her siblings had put their money together so that she could go and get a higher education. Moreover, I attended a scarification ritual, where once again the participants talked me through the entire ceremony as it was taking place. On another occasion I joined a participant when he had to appear in court for being involved in a violent attack. The attack was fuelled by jealousy towards a lover. On our way back from court the participant explained to me what had motivated his actions. Another important moment was when I happened to spend the weekend at Cebisile's house when she found out that her boyfriend was cheating on her. She was angry with her boyfriend and needed to offload. As a result she spoke in great detail of her relationship with her boyfriend, her doubts, and her own secret behaviour. Had I stayed with her a week later, I probably would not have heard any of this, because she would have returned to her quiet, respectful manner.

Adding to the informal atmosphere of the conversations was the fact that these conversations often took place whilst we were occupied with doing something else, like the dishes, walking through the township, going somewhere in the taxi, waiting in a queue, doing the laundry, watching TV. As opposed to the formal interview setting in which we would be sitting opposite each other whilst I would hold a notepad and a pen. As a result of being occupied the participants were not tense and spoke freely.

I also interacted with the participants when they were amongst each other. This enabled me to hear what they considered as interesting topics to talk about. It gave me an insight into how the participants interacted with each other. 'Speech in action', a concept that Richards describes as: "besides questioning his participants, the anthropologist listens to speech between natives in the natural context of daily life" (as quoted in Sanjek, 1990: 212). In these group conversations the atmosphere was relaxed. In some ways talking about sex proved to be easier in a group setting, because it would never get too personal, instead there was lots of group banter. I found out what could and what could not be spoken about with colleagues.

The downside of informal conversations is that these conversations, being casual, tended to change topics often and most of the time issues were not discussed in great detail. For this

reason I often used this technique as inspiration for topics that I would return to in interviews to discuss them in more detail.

4.4 Ethical considerations

Before flying to South Africa I obtained approval for this research from the Human Ethics Committee at the University of Canterbury. Arriving at the research location the directors of the two NGOs gave me written consent to conduct research at their organisations and to work with their staff members. During each first interview with the participants I explained what my research was about. I clarified that their participation was not obligatory. I wanted it to be clear that even though their managers had given me permission to do my research at their organisation, it would have no consequences if they chose not to participate in my research. I also explained what participation in the research entailed and how I would use the information they were giving me. Furthermore, I made it clear that they could choose not to answer a certain question, they could also choose to withdraw certain information from the research if there was something they regretted telling me, and at any time during the research they could withdraw altogether. Only after I had gone through all of this, I asked the participants if they were willing to participate. Each participant that I continued to work with after that first interview verbally consented to being part of this research. Only one of the participants decided to pull out. Her decision left me feeling confident that the participants did not feel pressured into participating by either me or the organisation. Another participant decided to participate, but would only do so under a few conditions. She was happy to tell me about HIV prevention in her community, but she was not going to answer any questions about her personal situation. Her ability to state her conditions once again confirmed that I was not making anyone do anything they did not want to do.

The participants have trusted me with their personal information. They have gone out of their way to help me. In return I have to make sure that what goes in this thesis does not harm them in any way. To protect their privacy I have altered the names of the participants and I do not describe their appearances. I have also changed the names of the two NGOs and the rural area I stayed in. My research notes are locked away or protected by passwords and the only people who have had access to my raw data were my supervisors at the University of Canterbury. Furthermore, at times I have omitted highly sensitive and potentially damaging information. Even though some of it could have contributed to the research, the wellbeing of the participants goes above the research interests.

Aware of the stigma attached to HIV/AIDS (Farmer, 2003; Herdt, 1987; Niehaus, 2007; Reid, 2010; Schoepf, 2001; Sontag, 1989), I decided before I even entered the research field that I would never ask my participants anything related to their HIV status. After spending almost a year with these participants they had shared plenty of personal stories, however their HIV status never came up in conversation. This has confirmed just how sensitive the matter is. For the same reason I never observed HIV pre and post-test counselling sessions. Despite this being interesting from a research point of view, I did not feel I had the right to be there when an individual finds out if he or she is HIV positive or HIV negative. The only time I experienced a counselling session in action is when I myself went for an HIV test at the 'Bafana AIDS Project'.

Sometimes caring for the wellbeing of the participants meant putting away my notebook and merely acting as a friend. In one situation it had taken many phone calls with one particular participant to arrange a time to meet in town and to go and visit his home. After the appointment was finally set it was cancelled because the participant's mother had passed away. Obviously the research took second place; the main priority was his well-being. I did not bother him with phone calls to organise a new time to meet. I only phoned him regularly to check how he was managing. Needless to say, with his life turned upside down, our meeting never happened, but he expressed great gratitude for my support.

4.5 Analysis

4.5.1 The various stages of analysis

I left for the first period of fieldwork in 2010. Although I had gone to South Africa with a research question in mind, I felt strongly about letting the situation 'on the ground' determine the exact focus of this thesis. I wanted to work with the topics, the worries and the solutions brought forward by the participants. I was keeping an open mind and did not want to narrow my focus until later in the research. As such I was using the 'funnel structure' approach (Hammersley & Atkinson, 1995: 206). To start off with, like Evans-Pritchard suggested, I gathered all sorts of data "even the most familiar and everyday things" (1976 [1937]: 254). Or as Malinowski put it, the "imponderabilia of actual life":

> …the routine of a man's working day, the details of his care of the body, of the manner of taking food and preparing it; the tone of conversational and social life around the village fires, the existence of strong friendship or hostilities, and of passing sympathies and

> dislikes between people; the subtle yet unmistakable manner in which personal vanities and ambitions are reflected in the behaviour of the individual and in the emotional reactions of those who surround him (Malinowski, 1922: 18, 19).

At the early stage I did not know what was going to be relevant for the end analysis. I could not foresee the connection between different kinds of information (Strathern, 1999: 3). After five months of participant observation at both NGOs I returned to New Zealand. Back home it was time to analyse the data, to look for patterns, to identify the topics that stood out as interesting, and to look for gaps in the information I had so far. Based on this, I was able to prepare the second period of fieldwork in more detail. First of all returning to the same place I knew what to expect of the people in the field. I knew what topics were open for discussion and in what way to position myself during these discussions. Furthermore, as a result of the analysis I knew exactly which questions I still wanted to ask. Whereas the first period of fieldwork had been explorative, the second period of fieldwork was going to be more purposeful. This is exactly the reason why both Malinowski and Evans-Pritchard recommended going to the field twice (Evans-Pritchard, 1951: 76; Malinowski, 1922: 13).
I left for the second period of fieldwork in June 2011. After five more months in the field I came home to write up the thesis. In the field I had written little reminders in my notebook throughout the day, which I used to transcribe the events and conversations at night. When I arrived back in New Zealand I entered all the transcripts into NVivo (qualitative data analysis computer software). I carefully read through all the transcripts identifying core themes which I coded in NVivo. By using this particular software I could bring all the material discussing a particular theme together and this formed the basis for the writing of the different chapters (Harrison, Cleland, & Frohlich, 2008: 300). This write-up is not merely a matter of pasting all the field notes together and adding an introduction and a conclusion. As Hammersley and Atkinson explain, when the data is gathered it does not come with headings and subheadings of analytical categories (1995: 208). Instead the writing is a process in itself. It is a reflective practice (Strathern, 1999: 7). It is during the writing that one starts to see how different findings are related and what is important to the argument and what is irrelevant (Strathern, 1999: 9). It is up to the anthropologist to order the material and to present it in a comprehensible way that explains the meaning of the material. As such the anthropologist imposes an imaginative order and structure in the chaos that is everyday life (Kondo, 1990: 7) and the anthropologist unintentionally creates a ‘second field’ (Strathern, 1999: 7). This thesis

is written by the outsider and due to its anthropological analysis might at times seem distant from the participants' experiences. It is my interpretation of the data collected during my interaction with the participants. As Morris expressed in her thesis, I want to stress that "this is my story about the stories of the" community HIV educators and might not be the story they themselves would tell (Morris, 2002).

4.5.2 Discourse analysis

Throughout my research I was introduced to different discourses at different times. For instance, when talking to the participants one-on-one during interviews, most participants told me that they may not have always used condoms in the past, but that working at the NGO had changed them and that they now used condoms consistently. However, when the male participants were amongst each other, they would brag about not using condoms, because condoms spoiled the sexual experience or even because they claimed to be immune for HIV. Initially this led me to wonder which one of these stories was the actual truth, thinking that this story would take primacy over the other stories. Eventually I realised that it was more interesting to study what the different stories were telling me, because as Spronk puts it: "whatever people communicate about their sexual lives is information, even though they leave out certain topics, emphasise certain matters, or boast yet others" (Spronk, 2006: 33). To get a better understanding for which discourse was chosen when and what this meant, I decided to make sense of the research material through a discourse analysis. The actual discourse analysis can be found in chapter seven, but here I will briefly explain my interpretation of discourse analysis.

Before I get into the discourse analysis, it is important to clarify my interpretation of discourse, which is based on several authors who have all been inspired by Foucault. Discourse is a pattern of meaning that can be found in both speech or text (Miles, 1992: 14). Like grammar, discourse cannot be seen or touched. Hence discourse is a hidden framework of ideas through which readers and listeners are able to make sense of what they hear and read (Berg, 2009: 215, 216). Discourse influences how we see and experience the world in both an enabling and a restricting way (Willig, 2008: 113). Although speech and text have been the most common sources for discourse analysis, discourse can also be found in for example what is left unspoken (Berg, 2009: 216; Foucault, 1978: 27; Miles, 1992: 14). The discourse analysis used in this thesis exists of six steps as designed by Willig (2008).

The first step to analyse discourse is to identify a discursive theme. An example of an object could be HIV prevention. From here all the fragments that refer to HIV prevention are

to be selected. Even fragments that do not use the words HIV prevention explicitly, but do discuss the theme, should be selected.

The second step in the analysis is to examine each fragment to establish from what discourse the theme is approached. For instance, when the object is HIV prevention, there could be fragments in which the participants approach HIV prevention from a tough masculinity discourse. In this case they might speak of HIV prevention as futile because they are not willing to worry about something that is bound to happen, or because they consider themselves invincible. There could also be fragments which approach HIV prevention from a health promotion discourse. In this case the participants might speak of HIV infection as a serious concern and HIV prevention as the only option. In a structural violence discourse participants might also consider HIV infection as a serious concern, but express a feeling of powerlessness due to a set of structural barriers blocking their HIV prevention strategies.

The third step in discourse analysis is action orientation. This step identifies what is gained, by using the different discourses. In Zulu culture one might find that by using the right discourse in the right situation one avoids acting disrespectfully and as a result one maintains credibility for which one receives respect. In a culture in which *hlonipha* plays a central role, this is an important motivator for action.

The fourth step examines from which subject positions the participants speak in different discourses. Discourses create positions; discursive locations which strongly influence the relationship between people (Miles, 1992: 14). For instance when a Zulu woman speaks as a mother to her children she speaks from a superior position. When this same woman speaks to her husband she speaks from a submissive position.

The fifth step is about determining how a particular discourse influences practice. As part of the discourse certain practices are rendered appropriate, whereas other practices are considered inappropriate. Dominant discourses create certain perceptions that people subconsciously internalise (Spronk, 2006: 19). This way discourses and subject positions both facilitate and limit what can be said and what can be done by whom, where, and when (Willig, 2008: 112). For example the tough masculinity discourse hinders subjects from suggesting or using HIV prevention strategies, whereas the health promotion discourse actively supports the use of HIV prevention strategies.

The final step in discourse analysis is examining how different discourses influence subjectivity. Discourses lead to certain ways of seeing and experiencing the world and ways of being in this world. In the health promotion discourse HIV prevention might feel like the

most important thing and HIV preventative behaviour might feel like the only right thing to do. In the structural violence discourse HIV can feel like another nail in the coffin. Individuals are aware of many threats to their health, but they feel there is nothing they can do.

4.5.3 Reflexivity

Although anthropologists are trained to reduce the influence of individual bias, I agree with Kondo that "any account, mine included, is partial and located, screened through the narrator's eye" (Kondo, 1990: 8). In ethnography the anthropologist is the biggest research tool. To make this 'scientific instrument' (Eriksen, 2001: 26) as objective as possible, anthropologists critically reflect on their personal characteristics that could affect the information they receive and the way they interpreted it (Hammersley & Atkinson, 1995: 223; Spronk, 2006: 35; Susser, 2009). "Reflexivity is the recognition that the researcher is part of the process of producing the data and their meanings, and a conscious reflection on that process" (J. Green & Thorogood, 2005,195).

So what are some of my personal characteristics that could have affected what information I got access to and how I interpreted it? I could say something about my age, about being a white non-South African and more particular about being Dutch, about being raised according to Christian values, about being someone who prioritises a healthy lifestyle, and about having a relatively promising career path ahead of me allowing for financial independence. These are all relevant characteristics and a great deal can be said about them. However, due to a shortage of space, I will focus on what I consider as two of the most important characteristics in relation to this particular study. These are me being a female researcher and me being in a long-term relationship without being married.

Just like Middleton, I found that being a woman made it easier for my female participants to talk to me about sexual matters (Middleton, 1993: 77). As a woman I established close relationships with the women of 'Women and Children First'. Had I been a man, it would probably have been difficult to get as close and to spend as much time with these women. Although I could have interacted with them at the NGO, it would have been difficult for me to gain access to these women in their private setting, as it was unconventional for men and women (who were not family) to 'hang out' in the domestic sphere. I was told boys and girls cannot be friends. Or as one lady put it: "you cannot leave a cat and a rat alone".

For this same reason it was a challenge for me to work as closely with the male participants of the 'Bafana AIDS Project'. On my first day in Faras, Mqondisi told me:

"Please make female friends. I do not mean to say you cannot talk to males, but for friends it would be better to have female friends". At the time, I did not make much of his advice. I even jokingly asked him if my boyfriend had asked him to pass that message on to me. My research relied on getting a male perspective so I had planned to find male participants and establish a friendly relationship in which they could 'open up' to me. I did not see a problem, because I have always had male friends. So throughout the research I organized to go and visit the participants, including the male participants, at their homes. The first weekend I planned one of these home visits I thought it was important to tell *Baba* that I was not going to be home that weekend, so I informed him openly of my plans to go home with one of the male participants to meet his family and to see where he grew up. It would have been possible to just tell *Baba* that I would be away for the weekend and to leave it at that. However, I thought that being open about my whereabouts, would indicate that nothing inappropriate was happening. To my surprise *Baba* plainly told me that he did not like the idea of me visiting these male participants overnight. He decided to phone his brother, who happened to work in HIV prevention and is familiar with qualitative research. His brother told him that my behaviour was acceptable as part of my job. Reluctantly *Baba* told me that he would try to accept that I was doing this as part of my research, yet I had to understand that this was not the proper behaviour of a young Zulu woman. This example does not only highlight the complexity of working with men as a female researcher, but also shows that by making mistakes, the researcher learns what is appropriate behaviour and what is not (Malinowski, 1922: 8).

After this mistake I decided that it would be better to keep my life with the host-family and my work with the participants separate. At home I behaved like a respectful Zulu daughter, as a woman who was sexually ignorant, and who did not speak her mind. I had come to realise that to behave any differently would be disrespectful towards my host-father. This is how I learned about the importance of concealment as part of the Zulu custom of *hlonipha*. Although my host-family knew I was doing research on HIV, they had no idea that I was spending large parts of my days talking about sex with my participants, especially male participants. At home the only men I interacted with socially were my host-family members. So at the homestead I interacted freely with my host-father, my host-brother, and the often-visiting host-uncles, Lindelani and Mandla. It was no problem if these host-uncles wanted to take me out of the homestead to show me something. I ended up spending a lot of time with Lindelani and Mandla. In fact I spent more time with them than their girlfriends did, as they

could not be seen together, because they were not married yet. More on this will follow in chapter 6. The importance of keeping my life as Zulu daughter and my life as HIV researcher separate was confirmed by my host-father's response when I told him about my home visits. It was confirmed a second time when I bumped into my host-uncle whilst I was with my participants in town. It was on a day that I had joined the 'Bafana AIDS Project' staff who had set up a mobile HIV counselling and testing facility in a central park in town. During a quiet moment I was interviewing Vusi in the work van. It was just the two of us sitting in the van when my host-uncle Mandla walked past. He jumped into the van to say hello and as soon as Vusi realised that Mandla was my host-uncle he sneaked out of the van. After Mandla had left, Vusi reappeared to continue the interview. The next chapter will explain that it is inappropriate for men to talk to women when they are in the company of male family members. Vusi knew better than I that these two worlds were to remain separate. This was reiterated when I visited Vusi and other male participants at their homes. I found out that in front of their family they could hardly speak to me. This meant that when I arrived at their homes, I would be looked after by their mothers, aunties and sisters. The male participants only interacted with me on the way to their home in the taxi, or when they took me away from the property to walk through the township or rural area. At the time I was puzzled. I thought that maybe Vusi had regretted bringing me home, until Vusi sent me the following text message that night: "I wl never 4get dis day, I thank u 4 cming, it means a lot 2 me and my family, gnite". It was clearly the face to face contact in front of the family members that was the problem, not my visit.

So, whereas a male researcher will struggle to interact with female participants in their private sphere, a female researcher will struggle to interact with male participants in their private sphere. However, just like Abu-Lughod I found that men generally speak more freely in public, so there is less of a need to meet with them in the private sphere (Abu-Lughod, 1986: 22).

Second, I am not married, but have been in a relationship for a long time. This is nothing unheard of in Faras, where marriage is extremely expensive and therefore often takes couples several years of saving. When I told men who were flirting with me that I had a boyfriend, they would not take my relationship status seriously and continued the flirting. Only when a man had started the process of paying *lobolo* for a woman, was the woman considered 'off the market'. Hence to indicate that I was in a long-term committed relationship, I started to tell men that I was in the process of getting married.

What was different about my situation is that I had been living together with my boyfriend for many years, whereas in Faras a boyfriend and girlfriend should not live together until they are officially married. As chapter six describes, couples might have a child together, but they cannot not live together. When I started to realise that co-habitation was considered disrespectful, I withheld from openly speaking about my boyfriend and I sharing the same house back in New Zealand. Had my boyfriend come to visit me, officially he could not have come onto the property of my host-family, let alone share my room. That would have undone all my efforts to act like a proper Zulu daughter. Instead of my boyfriend it was my mother who came to visit me in the field. Her visit only positively contributed to my position as young unmarried woman, because it reaffirmed that as an unmarried woman it was my parents who were looking after me. It fitted well with the morals of my host-family.

The fact that I had a boyfriend was helpful in many situations as it helped me relate to the participants. I could even share a bit of my personal life to establish a relationship of trust. However, the relationship between me and my boyfriend was at times very different from the relationships I observed in the field. At those times it did not help to reflect on my own situation, instead it was actually counterproductive. For instance, my boyfriend helps me with the cooking the washing and the cleaning. I can openly tell him what I like and do not like, both in general and in our sexual relationship. Financially I am not dependent on my boyfriend, which means that I would be able to leave him if he would mistreat me. Coming from this kind of relationship I initially found it hard to understand why, for instance, women would stay in a relationship when they knew their boyfriend or husband was cheating on them.

Chapter 5: Sexual socialisation of Zulu youth between 1816 and 2011

5.1 Introduction

Throughout the research many of the participants told me that according to 'traditional' Zulu culture it was taboo for parents to provide their children with sexual education. This statement forms the foundation of this chapter as it investigates several questions. First, what does 'traditional' actually mean? Second, if 'traditionally' parents could not provide their children with sexual education then where did the adolescents get their information? Third, to what extent does the taboo affect contemporary sexual socialisation?

In an attempt to answer the first question, this chapter starts with a discussion on 'tradition' and 'modernity'. The word 'tradition' is value-laden. It is associated with authenticity and being fixed, suggesting that 'traditional' customs have always been this way and therefore cannot be expected to change. The discussion shows that the reality is more complex than this, and argues that 'traditions' have experienced change in the past, and therefore it can be expected that they will change again in response to pressing issues in the future. I argue that the HIV epidemic is one of these pressing issues that enforces an adjustment to 'tradition'.

In answer to the second question this chapter starts with an historical overview that addresses the practices of sexual socialisation during five different periods. The first period describes sexual socialisation under Shaka's rule (1816-1828). Shaka was known for his political and military skills and for his violent and strict rule. With this strict rule he also controlled young men's sexuality. The next period describes practices of sexual socialisation in a time period under Mpande's rule (1840-1872). This is a time known for being relatively peaceful and stable, which more or less makes this period interesting for its non-events. A large number of social phenomena regarding sexual socialisation created in this period still form the benchmark for contemporary behaviour. The third period describes the influence of colonialism (1879- early 1900). Both the settlers and the missionaries disapproved of the Zulu sexual socialisation practices they found upon arrival. They banned several of these practices and suggested 'civilised' alternatives for sexual socialisation. The fourth period discussed in this historical overview is the chaotic period surrounding the end of apartheid (1980's-1990's). These years were filled with inter-generational conflict, political violence, and an increase in migrant labour, which together challenged surviving practices of sexual socialisation. The fifth period brings this chapter to the contemporary situation. It describes

the high-tide of the HIV epidemic in 2010-2011 through the narratives of the participants of this study.

This fifth period will also attend to the third question as it describes the narratives of the participants regarding the sexual socialisation they have been exposed to as children, and the sexual socialisation they in turn (plan to) provide their children with. This description includes alternative strategies that some of the participants used to ensure that their children have access to appropriate information without disrespecting the taboo.

Chapter one has indicated that the HIV prevalence in KwaZulu-Natal is exceptionally high and has given several explanations why KwaZulu-Natal has a higher HIV prevalence than any other South African province. This chapter investigates another contributing factor. After sexual socialisation practices were largely banned in the third period, the surviving practices were either disrespected or fell on deaf ears in the chaotic fourth period. During this same period the HIV epidemic entered the scene. I argue that the lack of sexual socialisation during these years is another reason for the high HIV prevalence in KwaZulu-Natal.

The focus of this thesis is on the ability of couples to negotiate and implement HIV prevention strategies. However, before this is discussed in chapter seven and eight, the following chapters describe factors affecting this negotiation such as sexual socialisation (as is done in this chapter) and gender relations (chapter six). Hence the following two chapters are background information chapters leading up to the focus of this thesis.

5.2 'Tradition' and 'modernity'

While describing the historical and contemporary practices of sexual socialisation, I found myself automatically using the concepts 'traditional' and 'modern'. Instead of being critical of the exact meaning of these concepts, I was merely using them in the conventional manner; the way I had been socialised to understand and use these concepts. However, Anderson (1983), Eisenstadt (2000, 1972) Spiegel and Boonzaier (1988), and Wolf (1997) point out that the exact meaning of 'tradition' and 'modernity' in popular use has remained vague, which has allowed for their widely varied use and abuse. The following literature overview demonstrates that 'tradition' and 'modernity' have become value-laden concepts and therefore require further specification when used.

Over the years the concept 'tradition' has been associated with being static, unchangeable, conservative, bound by cultural horizons, stuck, slow, homogenous, pre-literate, uncivilised, primitive, undeveloped, non-western, tribal, communal, backwards, pre-rational, intuitive, and being a-historic (Eisenstadt, 1972: 1; Spiegel & Boonzaier, 1988: 41-44; Wolf, 1997: 12).

The concept ‘modernity’, on the other hand, has been associated with being dynamic, innovative, adaptive, versatile, diverse, pluralistic, progressive, rational and with concepts like urbanisation, literacy, enlightenment, democracy, westernization, nationalism, reason, individualisation, and science (Eisenstadt, 1972: 1; Spiegel & Boonzaier, 1988: 41-44; Wolf, 1997: 13). Specific to the South African context, ‘traditional’ has been linked to African whilst ‘modern’ has been linked to Western (Spiegel & Boonzaier, 1988).

These associations suggest that there is a clear dichotomy between ‘tradition’ and ‘modernity’ (Eisenstadt, 1972: 1). Wolf critically observes that these associations position ‘modernity’ as hegemonic and ‘tradition’ as inferior (Wolf, 1997: 4,5). However, “traditional people are not merely helpless victims of the avalanche of modernity” (Eriksen, 2001: 250). Mchunu argues that ‘tradition’ and ‘modernity’ influence each other. Although ‘traditions’ have changed as a result of ‘modernisation’, these foreign ideas are never taken into a ‘traditional’ society unaltered. Instead they are integrated, rejected or reinterpreted according to the original culture’s worldview (Mchunu, 2007: 236). Local societies put their mark on ‘modernity’ by preserving elements of their ‘traditional’ identities. They “appropriate modernity on their own terms” (Eisenstadt, 2000: 19). Bourdieu makes a similar point when he describes how habitus responds to ‘modernity’. He acknowledges the innovative capacity of habitus when he writes that the Algerians responded “with creative reinvention to the discrepancy between the demands of the new economic rationality and their customary habits” (Swartz, 1997: 102).

Hence it should not be assumed that as a result of ‘modernization’ all ‘traditional’ societies will eventually develop into an homogenous ‘modern’ society (Wolf, 1997: 4, 5). Instead there will be ‘multiple modernities’. This means that Western ‘modernity’ is not the only authentic ‘modernity’ and that ‘modernity’ is not equal to westernisation (Eisenstadt, 2000: 1-3,14, 15). Similar to Mchunu, Wolf, and Eriksen, Eisenstadt argues that ‘tradition’ and ‘modernity’ are connected instead of divided and he supports this argument by pointing out ‘traditional’ elements in what is generally considered ‘modern,’ and ‘modern’ elements in what is generally considered ‘traditional’. Eisenstadt states: “In many countries modernisation has been successfully undertaken under the aegis of ‘traditional’ symbols and by ‘traditional’ elite” (Eisenstadt, 1972: 2). At the same time Eisenstadt states that “traditions in the ‘modern’ era, despite being greatly influenced by specific cultural premises and historical experiences, are distinctively modern” (Eisenstadt, 2000: 2). Anti-modern movements are an example of the latter. In this case their conservatism is a form of resistance, and although their practice

resembles practice from the past, it has been influenced by 'modernity'. They are 'modern' 'traditions' (Eisenstadt, 1972: 7; Spiegel & Boonzaier, 1988: 54).

Although the word 'tradition' is associated with antiquity, for something to be described as 'tradition' it does not necessarily have to go far back into history. Practices considered 'traditional' could be just as recently established as practices linked to 'modernity'. As long as it is experienced or imagined as if the 'tradition' was established a long time ago, it does not matter how long ago it was actually established (Anderson, 1983: 44; Spiegel & Boonzaier, 1988: 40). The 'invention of tradition' (Hobsbawm & Ranger, 1983) is a political tool to manipulate support for a newly introduced practice by presenting it as a long lost 'tradition' (Spiegel & Boonzaier, 1988: 48, 53, 54, 57). The use of this strategy has been central to the promotion of medical male circumcision and virginity testing as HIV prevention tools, which is discussed in detail in chapter eight.

When the word 'tradition' is used, people do not only assume that it refers to something that originated a long time ago. They also assume that the 'tradition' has not changed since its inception. As a result a 'tradition' is either perceived as an unquestionable authority and therefore treated with 'immense respect', or it is considered outdated and treated with 'dismissive disdain' (Spiegel & Boonzaier, 1988: 40). This idea was encouraged by the work of the majority of early anthropologists who dedicated their attention to "the aspects of social life that participants said had existed before contact with Western influences" and ignored the changing realities (Spiegel & Boonzaier, 1988: 44, 46). The idea that 'traditions' are static has since been criticised by the authors mentioned so far; instead they have argued that outmoded 'traditions' change and adapt in response to changing realities (Scorgie, 2002: 63; Vincent, 2006: 27; Wickström, 2010: 546). "Traditions (or culture or custom) constitute an adaptable resource for coping with contemporary situations (...) customary institutional complexes are modified to meet contemporary needs" (Spiegel & Boonzaier, 1988: 53).

In this chapter I support the idea that 'traditions' are not static but dynamic while looking at sexual socialisation practices. By comparing these practices throughout different historical periods this chapter demonstrates that the sexual socialisation of adolescents has adapted over time in response to social change. Based on this evidence, it is realistic to expect that 'traditions' around sexual socialisation can adapt again to include HIV prevention practices.

5.3 Period I: Shaka's Rule (1816-1828)

There are three reasons why I have chosen to start this historical overview with the years of Shaka's rule (1816-1828). First, I wanted to start this overview prior to colonisation, because

I realised that if I start at the time of colonisation I indirectly suggest that the Zulu way of life has remained unchanged until the moment European colonists forced change upon the Zulu kingdom. This would be counterproductive because I actually mean to show that 'traditions' change over time as they adapt to pressing contemporary issues (e.g. warfare, migrant labour, apartheid, and therefore also a deadly epidemic like HIV) and that the Zulu chiefdom had to respond to changes long before colonialism arrived in South Africa. This is in accordance with Wolf (1997), who states in his book 'Europe and the people without history' that those societies classified as 'primitive' have often been denied their own history, even though prior to colonialism these societies already interacted with other societies and as a result experienced change. Second, for the sake of the argument I could have gone even further back into history; however, an extensive search through the history books produced few resources describing the time prior to Shaka's rule. This can be explained by the fact that the first written records describing Zulu society were written by Europeans and it was around the time of Shaka's rule that the first Europeans came into regular contact with the Zulu population. These initial years of contact have been documented by traders, pioneer settlers, missionaries, and linguists. They all had their own perceptions and intentions, and as a result these sources contradict each other and some have been highly disputed. It is therefore important to use them carefully. The final reason why I start this overview with the years of Shaka's rule is because Shaka was the first Zulu King to actively work on building a shared identity among the Zulu population. With all the changes he introduced, he laid down the foundations for Zulu nationalism and he turned a chiefdom into a kingdom.

Prior to Shaka's rule people lived in scattered self-sufficient homesteads, where the female family members generally looked after the crops and attended to the domestic chores and the male family members herded cattle, and looked after the heavier building tasks and land preparation (Beinart, 2001: 17; Gluckman, 1940: 25; Guy, 1982: 168). However, by the late 18th century the population had outgrown the land available to them. Further expansion was complicated, as the periphery of their territory had reached desert, rough mountains, the sea, and rival chiefdoms. Consequently, the search for land and water supplies resulted in a time of war also known as the *mfecane* (Thompson, 2001: 81). When Shaka became King in 1816, he started a professional army, introducing change to the way Zulu warriors fought. He also initiated several changes to the Zulu way of life. Shaka abandoned male circumcision, an initiation ritual that had previously united members of related families. As a replacement for male circumcision Shaka introduced mandatory military service based on age regiments.

Upon reaching puberty, young men were sent to army barracks scattered throughout the country where they were trained as warriors. Peers from the same clan were intentionally assigned to different barracks and warriors lived away from their family homestead most of the year to undermine the loyalty individuals felt towards their own clan and encouraged a feeling of loyalty towards the larger kingdom (Gluckman, 1940: 26-30; Thompson, 2001: 84). While serving in Shaka's army, which would be for a period of approximately twenty years, the warriors were not allowed to get married or to have any contact with women. They would have to wait for Shaka's permission to be released. This would not be granted on an individual basis; instead the whole regiment would be released together. Upon retirement a warrior received a section of land and several head of cattle to support himself and his future family. He was now expected to get married to a woman from a corresponding female age set (Guy, 1982: 169,170; Olsen, 2001: 52; Thompson, 2001: 84). By conscripting young men into his army upon reaching puberty and only releasing them to get married, it seems that Shaka closely controlled young men's sexuality and discouraged casual sexual contact.

The system of age regiments was not the only tool Shaka used to enforce loyalty to the kingdom. He also drew on regular collective rituals to create a feeling of unity. For instance, he made the King and the royal ancestors central to the annual first fruits festival. Furthermore, the customs of the Zulu royal lineage became the customs of the kingdom, the Zulu dialect became the language of the kingdom, and Shaka declared that every inhabitant, regardless of his origins, should become a Zulu, owing allegiance to the Zulu King (Thompson, 2001: 84). Shaka aimed to create an 'imagined community' (Anderson, 1983). Shaka did not call it this, but in hindsight his actions fit Andersons's terminology. Shaka's centralisation efforts can be compared to the European process of nationalism, which at the time was closely linked to 'modernity'. Hence Shaka's active establishment of shared 'traditions' could be described as a 'modern' practice. Although this push for centralisation had a direct impact on the everyday lives of the population, it did not cause the population to immediately identify themselves as Zulu (Thompson, 2001: 85). Wright (2009) suggests that initially it was mainly the Europeans who identified the group of Africans in that particular area as Zulu. Eventually in the 20th century, in opposition to colonialism, a more generic Zulu ethnic identity emerged in which the majority of Africans in both Zululand and Natal acclaimed the Zulu King as their leader (Wright, 2009: 35). Despite this delay, I suggest that the seeds of a Zulu identity were sown by Shaka and the drastic changes he introduced.

In a relatively short period of time Shaka enforced a "cultural transformation" (Wolf, 1997: 347). Initially the changes were seen as unnatural and foreign and were met with some resistance. Yet over time this way of life became the new norm and generations later, particular customs of Shaka's time are referred to as Zulu 'traditions'. This demonstrates how over time newly introduced collective rituals can come to be perceived as 'traditions'. It also highlights that 'traditions' can be a matter of selective memory; whereas the ritual is remembered, the initial resistance is forgotten. Furthermore, only certain rituals are preserved by the next generations and get referred to as 'traditions', whereas other customs are merely forgotten. For instance, currently the first fruits festival still takes place, while the custom that young men cannot get married until the King gives them permission has long faded.

5.4 Period II: Mpande's rule (1840-1872)

After Shaka and Dingane, it was Mpande who followed as the Zulu king. His rule marked a relatively peaceful period in history. Shaka's strict rules regarding recruitment to the army were relaxed and colonialism had not yet impacted on the lives of the Zulu people. I have chosen to attend to this period because many of the customs established during this period are currently referred to as 'traditions' and are still practiced today, be it in a slightly altered form.

As life was relatively stable during this period it is remembered as a period in which Zulu society functioned well. I argue that this is why the practices of this time are often glorified. To a certain extent these practices have become the 'benchmark' against which current practices are compared and judged (Mchunu, 2007: 236). Later on, when this chapter discusses traditionalists who suggest a return to 'tradition', they are generally referring to the practices common in Mpande's time. They argue that society is being punished for straying from these practices. Considering the theme of this chapter, I only describe the practices related to sexual socialisation. Please note that the following practices are described in an idealised manner to aid the readability. I do not mean to imply that everyone acted in this exact manner. However, I do believe that these practices informed individuals' dispositions which may not determine but certainly influences individual practice.

5.4.1 *Hlonipha* (expressing respect through avoidance)

Under Mpande's rule youth could openly discuss sexuality during puberty rituals, among siblings, with peer advisors, and with grandparents. However, it was taboo to speak about sexuality with or in the presence of their parents, instead the youth had to avoid at all times

that their parents would be confronted with their sexuality (Cheetham, Sibisi, & R.J., 1974: 43; Gaitskell, 1982: 340; Raum, 1973: 279). This brings attention to the practice of *hlonipha*, which refers to linguistic and behavioural practices through which someone in an inferior position can express deference to someone in a superior position. As part of *hlonipha* children are expected to express respect to their parents, wives are expected to express respect to their husbands, and initiates are expected to express respect to their in-laws. However, it is not entirely a one-way phenomenon; to some extent the person in the superior position also has to show respect to the person in the inferior position (Raum, 1973: 1,5). As a central concept to Zulu culture, *hlonipha* will also play a central role in this thesis. An important element of the concept of *hlonipha* is avoidance. Hence, *hlonipha* is the expression of respect through avoidance (Herbert, 1990: 457; Hunter, 2010; Mchunu, 2005; Raum, 1973: 1; Rudwick, 2008: 152). It is not so much about not doing something, but making sure that it goes unnoticed when it is done. This ties in with the idea of discrete indiscretions, a concept that was introduced in chapter two. One example is given further along in this chapter, when it describes how boys secretly visit their lovers at night. Their behaviour can be perceived as respectful as long as they ensure that their lover's parents do not see them on their property. Another example follows at the end of this chapter which describes respectable strategies for parents to ensure that their children are informed on HIV prevention.

5.4.2 Puberty rituals

When girls had their first period and boys had their first nocturnal emission, it was considered time for these adolescents to learn about appropriate sexual behaviour (Delius & Glaser, 2002: 31). Due to the aforementioned taboo, sexual socialisation was not provided by parents in the family home, instead it was organised by other members of both the family and the community during official puberty rituals (Krige, 1968; Leclerc-Madlala, 2001b; Marcus, 2009). For these rituals, groups of girls and groups of boys were secluded from the community in an isolated hut for several days (Krige, 1968: 93). In the hut they would be taught by either elder women or elder men about the proper interaction between boys and girls (Krige, 1968: 93; Ndinda et al., 2011: 4). During this period the rules were explained through educational talks, songs, and dances (Buthelezi, 2006: 4). Krige (1968) has recorded several of the songs that were sung during the puberty ritual of the girls, of which the following song is an example:

Obaba nomama baguduz' endlini	Father and mother are poking about in the hut

Nje babangani na?	What are they contending for?
Babang' inhlunu	They are contending for the vagina
Ibuye nobani?	Who ultimately got it?
Ibuye nobaba	Father ultimately got it
Umama pho?	What about mother?
Ubuye nenjengenjenge emhlope	She got white sticky stuff
Ezal' abantwana	Which begets children

(Krige, 1968: 188)

These rituals created age-set groups and after the rituals were finished further information about sexuality was shared within these groups. These peer groups also formed a social control network as the group members closely monitored each other's behaviour (Delius & Glaser, 2002: 31). The puberty ritual age-set groups could be considered as a slightly adjusted version of the army age-set groups established under Shaka's rule, which in turn had replaced the male circumcision age-set groups of even earlier times.

5.4.3 Peer advisors

Another route to information about sexuality for girls was their older sisters. Vilakazi (1962) writes that when girls turned 14, they were allowed to listen to the conversations of their older sisters when these spoke about sexuality. They were also allowed to ask them questions. The girls were often present when their older sisters were approached by boys. From this interaction they learned how to respond when being courted by boys. Similar to the young girls, boys also listened to their older brothers while they discussed the difficulties they experienced whilst courting girls or the medicine they used to make girls fall in love with them (Vilakazi, 1962: 47). Furthermore, young boys observed courting couples while they were out herding the cattle. These well-informed herd boys were often approached as advisers or messengers by both boys and girls.

Within the girls' peer group there was also a specially appointed *iqhikiza*[19] (female peer advisor) (Krige, 1965: 104). She was a slightly older girl who already had some sexual experience, but who was known to have conducted herself well in her younger years (Cheetham et al., 1974: 43; Delius & Glaser, 2002: 33). She advised the girls about life in general and about sex while they participated in group work such as fetching wood, carrying water and working on the land. She spoke very openly and the girls could ask her anything.

[19] *Iqhikiza* is singular and *amaqhikiza* is plural

No topic was considered taboo (Cheetham et al., 1974: 43). The *iqhikiza* also monitored and managed the love life of the young girls (Delius & Glaser, 2002: 33). A girl was not allowed to respond to any advances made by young men unless the *iqhikiza* had given her permission and the *iqhikiza* only gave permission when she felt that the girl was ready and would know how to behave properly (Buthelezi, 2006; Harrison & Montgomery, 2001; Krige, 1965).

5.4.4 Sexual experimenting

After the adolescents had received sufficient information through the puberty ritual, peer groups, siblings, and *amaqhikiza*, they were encouraged to experiment. The relationships they started were not taken seriously, they were not expected to last; their only function was gaining experience (Cheetham et al., 1974: 43; Vilakazi, 1962: 51). Penetrative sex was strictly forbidden before marriage. During the puberty rituals, the youth were warned that pre-marital pregnancy would lead to public humiliation and exclusion from their age-set groups (Cheetham et al., 1974; Delius & Glaser, 2002, 32; Mchunu, 2005). A girl would be considered soiled (Vilakazi, 1962: 56) and it would reduce her chances of getting married (Delius & Glaser, 2002: 32). The youth were also warned that it would trouble the relationship with their parents and their ancestors (Vilakazi, 1962: 56). For the parents it was considered a serious embarrassment, as it reflected poorly on their disciplining skills. It would also cost the parents a head of cattle (or the equivalent in monetary value): if their son impregnated a girl outside wedlock they had to pay a head of cattle as "damages" to the girl's family, and if their daughter became pregnant outside wedlock the mother would lose out on getting the extra head of cattle as a reward for protecting her daughter's virginity when the daughter would eventually marry (Xaba, 1994: 34). Due to the importance attached to virginity, the hymens of adolescent girls were regularly checked to see if they were still intact (Raum, 1973: 86). Chapter eight provides more information about the practice of virginity testing. Out of appreciation for the physical needs of the adolescents, alternative sexual practices that allowed sexual pleasure without risking pregnancy were promoted by the senior peers (Buthelezi, 2006: 4; Delius & Glaser, 2002: 33). Buthelezi (2006: 5) mentions a variety of these practices, like *ukucumbazana* (fondling and body to body rubbing), *ukuteketisana* (sexual fantasising accompanied by love talk and praises), and *ukusoma*[20] (intercrural sex).

[20] *Ukusoma* is also known as *ukuhlobonga.* According to Vilakazi *ukuhlonbonga* is an old word and his participants spoke of *ukusoma*. The participants I asked in 2010 were not familiar with *ukuhlobonga*, but did know *ukusoma*. Therefore I will use the term *ukusoma* in this thesis.

Out of all of these practices *ukusoma* has been recorded most often in the literature and Krige described it as follows: "[A girl] has to lie on her left side, legs crossed and pressed together so tightly that the penis gets no further than the clitoris. The semen must be caught in the left hand and then carefully wiped over the thigh and leg till dry" (Krige, 1968). The following is a song that is sung during the puberty ritual describing *ukusoma*:

Valela wovalela ubolo	Shut it out – you should shut out the penis
Isingcingcingci	In a succession of tight closings
Lwabhebha, luvalele ubolo	It copulates, shut it out, the penis

(Krige, 1968: 187)

The encounters between boys and girls were not secret, or at least not among the peers, who knew exactly who was courting whom. This resulted in effective public control over the actions of young couples (Cheetham et al., 1974: 43; Vilakazi, 1962: 51). Vilakazi described what happened when a boy and a girl were given permission by the *amaqhikiza* to start *ukusoma*. Due to the *hlonipha* custom, the boy visited the girl when it was dark in order to avoid being seen by her parents or brothers (Raum, 1973: 285). Prior to marriage her family members were never to see him on their property. The only people he could be seen by were her sisters and sometimes her grandmother. Although the parents may have suspected that their child was in a relationship, they were not to be confronted with it (Delius & Glaser, 2002: 34; Harrison, 2010). If the mother thought something was happening she changed the sleeping arrangements so that the girl could not sneak away at night. But as Vilakazi puts it, "it would be beneath her dignity to pry into her children's affairs and she would act as if she knew nothing about the matter" (Vilakazi, 1962: 53). Hence children tried hard to hide their love life from their parents and their parents made sure not to go looking for it. When the boy sneaked onto the property in the dark he was met by the girl's older sister. She told the boy to behave himself and brought him to the vacant hut where the girl would come and join him. The older sister told the girl "*ungazeneki izinkomo zikababa"* (do not expose our father's cattle, meaning do not lose your virginity). After the boy and girl spent the night together, the girl had to return to the hut where she normally slept before her parents woke up (Vilakazi, 1962: 53,54). More about these 'secret' visits follows in the next chapter. In comparison to the period under Shaka's rule, there was more sexual freedom in the period under Mpande's rule. However, as a result of the puberty rituals and peer advisors the youth knew exactly what was expected of them and their practices were closely monitored by peers, grandparents,

siblings, community members, and *amaqhikiza*. Hence, in my opinion, during this second period sexuality is still closely monitored and regulated.

5.5 Period III: Colonialism (1879 - early 1900)

After the relatively stable years that allowed for an organised sexual socialisation system, the arrival of both settlers and missionaries introduced considerable changes to this system.

5.5.1 Settlers

In the 1820's the British founded port Natal (later named Durban and now referred to as eThekwini). From that time the Zulu south of the Thukela river gradually started to interact with the Europeans. Initially this only involved some trading. The majority of Zulu rejected the jobs offered by the British on the newly established sugar plantations, which resulted in the British bringing in indentured labourers from India (Beinart, 2001: 46). Throughout most of the 19th century contact with the settlers remained limited and did not cause any fundamental changes to the structure of the Zulu kingdom north of the Thukela river (Guy, 1982: 171).

The real changes only started happening near the end of the 19th century and at the start of the 20th century when a number of events led Zulu families to become reliant on the migrant labour system. In 1879 the British conquered Zululand and this was followed by the implementation of a hut tax and later a poll tax by the British rulers, which the Zulu initially paid by the sale of their produce. It was not until several natural disasters took place that the Zulu were made dependent on wage labour. The biggest of them was the 1896-1897 Rhinderpest epizootic, which killed the majority of Zulu cattle. This disastrous loss of cattle impacted the food supplies, it made it harder to pay the *lobolo* (an eleven head of cattle bride wealth) to get married, and it complicated honouring the ancestors with offerings. It also meant that the majority of homesteads no longer had enough produce to sell in order to pay for their taxes. This dependency on wage labour worsened when in 1913 the Natives Land Act was introduced. This legislation restricted African ownership to less than 7 % of the land of South Africa (Thompson, 2001: 163). Africans were forced to live in so called 'native reserves' (Marks, 1987: 15). According to Beinart (2001: 10) many historians talk of 13%, but that was only after the 1936 Native Trust and Land Act came into place. The limited size of these native reserves and the large number of people that were expected to live there, did not leave enough land to grow crops for all (Carton, 2006: 98). For the majority of the Zulu homesteads this was the final blow to their self-sufficiency. As a result of these events they

were forced to send some of their young men to labour for wages in industrial centres, including the mining industry (Beinart, 2001: 21, 98; Carton, 2000: 53; Guy, 1982: 184).

Capitalism and the European lifestyle started to have a bigger impact on the Zulu way of life in general, and sexual socialisation in particular. First, some boys left the reserves as migrant labourers prior to puberty, which meant that they had not yet gone through the system of sexual socialisation. As a result they arrived in town ill-informed about sexuality and the importance of non-penetrative sex. In town itself, the sexual socialisation system had broken down. The only thing these young men knew about sexuality was what they heard from the men around them. Their message was different from the one passed on during the puberty rituals described under Mpande's rule. Amongst the migrants a discourse of tough masculinity, which described *ukusoma* as "unfashionable and babyish playing" and which encouraged promiscuity prevailed (Delius & Glaser, 2002: 38-45; Gaitskell, 1982: 352). Hence, due to a lack of social control in town, the youth did not get the same guidance, nor was their behaviour closely monitored.

Second, there were also migrants who started a family after they moved to the urban areas. For them it was hard to provide their children with the same sexual socialisation they had experienced themselves, because there were no 'traditional' peer groups in their new surroundings. Furthermore, because they were living in nuclear families they did not have the grandparents nearby to teach their children about sexuality. This left only the parents available to talk to their children about sexuality, something they had always known to be taboo. As a result these parents had no template for talking to their children about sexuality, which generally resulted in an overall silence around the topic.

Third, back in the reserves households experienced a weakening of parental authority as a result of a generational conflict (Carton, 2000: 3). This conflict was caused by the absence of fathers from the household as they worked as migrant labourers. Furthermore, many of the migrant labourers were young boys who ended up in a financially stronger position than their fathers. Under Mpande's rule the norm had been for fathers to provide their sons with cattle to pay *lobolo*. As such, sons depended on their fathers and they expressed their respect through the *hlonipha* practice. They lived according to the idea that "in homestead hierarchy no youth is the equal of a man" (Carton, 2000, 36). However, as a result of the Rhinderpest fathers had lost all their cattle. Sons now paid for their own *lobolo* in cash with the money they earned as migrant labourers. Suddenly fathers became dependent on the income of their sons. This role reversal challenged the *hlonipha* custom and it diminished the authority

fathers had over their sons (Carton, 2000: 38, 53, 59, 94; Spiegel & Boonzaier, 1988: 47). A final contributing factor to this intergenerational conflict was the introduction of the poll tax. The younger generation resisted paying the tax, but the older generation gave in to the colonial powers. This caused the youth to lose respect for the older generation (Mchunu, 2007). The industrial revolution led to a decrease in sexual guidance and monitoring of Zulu adolescents (Delius & Glaser, 2002: 38-45). This resulted in what was referred to as a 'dangerous sexuality', which in turn led to an increase in pre-marital pregnancies and syphilis (Delius & Glaser, 2002: 38-45).

5.5.2 Missionaries

The missionaries arrived in South Africa roundabout the same time as the settlers. Throughout the 19th century Zulu communities were gradually introduced to Christianity through mission stations of different denominations (e.g. Anglicans, Methodist, Lutherans, Catholics) (Beinart, 2001: 25). The prudish missionaries were shocked when they were confronted with Zulu nudity, the practice of *ukusoma*, and the openness with which sexuality was discussed during puberty rituals and among peers (Marks, 1987: 23). At the mission schools they did not allow any talk about sexuality. Neither were the students allowed to participate in the Zulu puberty rituals (Cheetham et al., 1974: 44; Magwaza, 2009; Vilakazi, 1962: 47). Instead these mission schools promoted the idea that girls were to remain pure until marriage, which meant no courting and absolutely no sexual practice, in whatever form, prior to marriage. Missionaries perceived puberty as a dangerous stage in a girl's life. Therefore, teachers strictly monitored their pupils behaviour and kept them busy with activities such as scouting (Marks, 1987: 23; Vilakazi, 1962: 47). Scouting promoted the Christian ideology: "a wayfarer is clean in thought, word and deed" (Gaitskell, 1982: 346). When it came to sexual education the mission schools expected mothers to preach to their daughters about purity and abstinence (Marks, 1989: 228). Zulu mothers, however, hesitated to talk to their daughters about sexuality, because they had always been taught that it was taboo for parents and children to discuss this matter (Cheetham et al., 1974: 45). These mothers had never experienced their parents talking to them about sexuality, which meant they had no template to follow when addressing their own children, so most of them remained silent instead. Hence, adolescent Christian girls received little or none adult advice regarding sexuality (Reader, 1966; Vilakazi, 1962: 47). Nevertheless, like other adolescent girls, they still experienced courting. Consequently these girls entered relationships without information and because they had to keep the relationship a secret they could not ask anyone for advice

either. Several authors have noted that during the early years of Christian influence on Zulu communities there was a higher number of pre-marital pregnancies among the Christian adolescents than there was among the non-Christian adolescents (Cheetham et al., 1974: 45; Delius & Glaser, 2002; Gaitskell, 1982: 342; Marks, 1987: 24, 228; Vilakazi, 1962: 47, 52).

The following is a striking example of a Christian woman entering a relationship completely unprepared. The example is an excerpt from the life story of Christina Sibiya as she told it to American writer Rebecca Hourwich Reyher in 1934. In 1915 King Solomon kaDinuzulu decided to marry fifteen year old Christina Sibiya, a Zulu woman raised and educated mainly by missionaries. When it came to their first night together, King Solomon was shocked to find out that she had no idea what was expected of her. He called out for his assistant Maphelu and asked him: "tell her what is expected of her in her position. Tell her whatever it is that she ought to know, that those Christian women who have brought her up have forgotten to tell her" (Hourwich Reyher, 1948: 34). Maphelu was clearly insulted by the request of the King because he murmured out of the king's earshot: "so this is what I, Zulu warrior, have been reduced to doing for my King. Woman's work! Why did not a '*qhikiza*, whose duty is to prepare young girls for their woman's responsibilities, tell her? I'm just an auntie, an old lady!" (Hourwich Reyher, 1948: 34).

Throughout the Victorian era, African sexuality was described as wild, animal like, exotic, irrational, and immoral (Saethre & Stadler, 2009: 277). More recently, due to the HIV epidemic in KwaZulu-Natal, Zulu sexuality has come back into the limelight, and, as discussed in detail in chapter three, once again Zulu culture was branded as dangerous (Saethre & Stadler, 2009: 279). The historical overview in this chapter has argued that Zulu sexuality prior to western interference was far from out of control. Instead youth was well-informed and closely monitored. While the settlers and missionaries thought they were bringing development to the Zulu population, by banning 'traditional' rituals and suggesting unsuitable alternatives they left a gap in the sexual socialisation of Zulu youth.

5.6 Period IV: Towards democracy (1980's-1990's)

The fourth period attended to in this historical overview is a more recent one, namely the years leading up to the end of apartheid and the start of the South African democracy, which was in 1994. A combination of the following three factors: intergenerational conflict, political violence and an increase in migrant labour resulted in a 'dangerous sexuality' right at the time when the HIV epidemic became established in South Africa.

First, the intergenerational relations came under tension once again when the economic recession hit in the 1970's causing many fathers to lose their jobs or suffer a decrease in pay (Campbell, 1992: 619). This was not the only reason why the youth lost respect for their elders. Similar to when youth were disappointed in the elder generation for not opposing the poll tax in 1907, in the 1970's youth were disappointed because they observed a lack of resistance among their elders against the oppressive apartheid regime. The youth themselves had started to openly resist the apartheid regime (Campbell, 1992; Mchunu, 2007). An example of this was the so-called 'Soweto uprising' in 1976 in which school children protested against Afrikaans becoming the language of instruction in schools. The intergenerational conflict made it harder for parents to discipline their children and to provide them with information and advice regarding sexuality.

Second, even though South Africa and particularly President Mandela has received worldwide praise for the peaceful transition into the South African democracy, the years around 1994 were still filled with unrest and violence. These years are of particular interest to this thesis because they coincided with the emergence of the HIV epidemic in South Africa. Chapter one has described how any initiatives from the apartheid government regarding HIV prevention were met with suspicion, and how the political violence disrupted formal platforms of education and also led to a fatalistic and invincible attitude amongst the youth. Instead of worrying about premarital pregnancies or STDs that would affect a person's life further down the line, many people were merely occupied with direct survival (Bonnin, 2000).

Third, as a result of high levels of unemployment and an increase in wages in the mining industry in the 1980's, there was an increase in men moving to the mines. Chapter one has explained how in the 1940's "the social dislocation and family disruption induced by the migrant labour system create[d] the right conditions for rapid transmission of sexually transmitted infections" (Karim as cited in H. Phillips, 2004: 32). Hence history has repeated itself, only this time the STD they were risking was not syphilis but HIV.

5.7 Period V: High tide of the HIV epidemic (2010-2011)

This chapter aims to show that as times are changing, 'traditions' either change accordingly to remain relevant, or they slowly disappear. This is a case of appropriating 'traditions'. Hence although 'traditions' seem fixed, they are constantly adjusted to the current reality. The 'tradition' of *lobolo* for example has over time experienced several alterations to deal with changes in society. *Lobolo* used to consist of a certain number of cattle, which the groom

would present to his father in-law after he himself had received them from his father. However, the rhinderpest changed this. Fathers no longer had enough cattle to give to their sons. Consequently, sons had to start working for wages to pay for *lobolo* themselves (Carton, 2000: 38, 53,59, 94; Spiegel & Boonzaier, 1988: 47). Often this meant that the *lobolo* was no longer paid in cattle but in cash, or at least the larger part of it would be. This shows how the *lobolo* 'tradition' was altered in response to the contemporary reality of that time. Throughout the 20th century it even became difficult for wage earners to save enough money to afford *lobolo*. This introduced further changes to the *lobolo* practice. In some cases it meant that a couple moved in together prior to *lobolo* being fully paid, either to be paid off later, or never to be completely paid off at all. Other cases would see employers get involved in the practice of *lobolo.* Loudon, for example, described how white farmers provided loans for their workers to pay *lobolo* (Loudon, 1970: 99). Hence the 'tradition' of *lobolo* has seen several different versions throughout the last century alone.

Despite 'modernity' forcing considerable changes upon 'traditional' customs, it is important to note that those who moved to town and those who converted to Christianity did not necessarily fully submerge into western 'modernity'. Instead some of them 'creatively reinvented' the foreign influences to fit their own reality (Swartz, 1997: 102). Or like Eisenstadt stated: "they appropriated modernity on their own terms" (Eisenstadt, 2000: 19). The following example, which describes how a group of traditionalists spent their wages, supports this argument. Among Red (traditionalist) Xhosa a man's lifework was to establish a flourishing homestead with huts, cattle, and arable land so he could provide for his family (McAllister, 2006: 57). This is similar to the Zulu ideal of *umnumzana*, as described by Hunter (2005). When the Red Xhosa eventually signed up for migrant labour, which they considered a necessary evil, they did not use their wages to buy consumer items. Instead they used their economic capital to build their homestead; they bought ploughs, hoes, cattle, and grain. "Red migrants complied to the extent that they had to, but converted the economical capital so gained into forms of rural capital (economic, social and cultural) designed to build their homesteads" (McAllister, 2006: 61). They worked only as much as was needed to maintain the homestead. "Reds transformed and recontextualised migrant labour, they incorporated it into their rural economy and social system, remade it to fit into their society and adapted the latter to facilitate this" (McAllister, 2006: 61). Hence they used capitalism to their advantage without fully taking on western morals and values. The fact that their practice

does not exactly resemble western morals and values, does not make their practice less 'modern', because there are multiple 'modernities' (Eisenstadt, 2000).

'Traditions' (despite their authentic and fixed image) experience adjustments over time in response to 'modernity'. This is not to say that 'modernity' is merely copied. Instead pressing 'modern' issues are appropriated in ways that are suitable to the local context. This has happened throughout Zulu history and I believe it has also happened in response to the HIV epidemic. The following will show how practices around sexual socialisation have been appropriated to respond to the threat of the HIV epidemic. It describes participants' experiences of sexual socialisation. Where did they get their information when they were adolescents? What role do the participants (plan to) play in the sexual socialisation of their children? To get a feeling for the complexity of the current situation, I start with a detailed description of one participant's experiences. Her name is Sibongile and she works for 'Women and Children First', one of the NGOs at the centre of this thesis. This narrative provides a description of the context in which young people today learn about sexuality. Sibongile's narrative is compared to the anecdotes of other participants in the remainder of this chapter.

5.7.1 Sibongile's lifestory

Sibongile was born in 1962 in Umlazi, one of South Africa's largest townships on the outskirts of Durban. Although Sibongile has lived in townships around Durban most of her life, she still has close links to her family homestead in deep rural Zululand and she often travels there to attend family ceremonies. Sibongile is the fifth of nine children. Sibongile's childhood was influenced by capitalism, as her father was a wage labourer for an international company. It was also influenced by other elements of 'modernity', as they lived as a nuclear family, attended church, and all the children received schooling. Sibongile's father wanted to see his children become nurses and teachers. Despite this 'modern' outlook on life, the family also practiced particular Zulu customs. The family homestead in Zululand still played a central role during important life events. However, the rituals were not practiced in exactly the same way as they had been practiced generations earlier. Instead they were adapted to contemporary circumstances. Although Sibongile's father was part of the capitalist world, he implemented Zulu ideals by using his economic capital not only to look after his nuclear family, but also his extended family by paying school fees for nieces and nephews. He transformed 'traditional' perspectives to incorporate 'modern' day reality. Life in the township was very different from the life of Sibongile's extended family who had stayed

behind in rural Zululand. Whereas Sibongile had access to sealed roads, sewage, shops, transport, and electricity, in rural Zululand the living circumstances were more basic. Still these deep rural areas had not remained untouched by 'modernity'. Grandmothers went and collected their pensions at the community hall. Working family members commuted to Richards Bay and brought back their wages, 'modern' products, and ideas from the city. Other family members who had permanently moved to Durban visited the rural homestead in their private cars.

After completing her matriculation examinations in 1982, Sibongile became pregnant and gave birth to her son Bheki. She never married Bheki's father. Sibongile explained that the father of her son had given her the impression they would get married, but this never happened. At this time, due to low wages and unemployment, men struggled to finance weddings which resulted in an increase in premarital pregnancies (Campbell, 1992). In the next chapter I further address the negotiation that takes place between men and women, in which women try to find out if the men are committed to them, or if they perceive the relationship as just for fun. Among township youth *ukusoma* was considered old-fashioned. Men were put under pressure by their friends to have sexual relationships before marriage and women were put under pressure by their boyfriends. They would tell the women; 'if you love me, you have sex with me'. Furthermore, in the township there was less social control than in the rural areas, because people lived in anonymity and minded their own business. This meant that Sibongile's boyfriend could be with another woman without Sibongile finding out. Also when Sibongile became pregnant it was difficult for her family to trace the family of her boyfriend to either require marriage or ask for 'damages' to be paid. The fact that Sibongile became pregnant outside a committed relationship could also be a result of the lack of sexual socialisation when she grew up. Her grandmother lived a day's worth of travel away in Zululand and her parents did not discuss sex with her. In the township she was never linked up with peer groups or *amaqhikiza*. As a result Sibongile had not been taught how to prevent pregnancy and had not been warned about the risks of STDs.

Sibongile started her studies to become a teacher, but when both her parents passed away there was no longer money for her to continue her studies. She had to find work instead. In 1994, Sibongile's oldest sister, a midwife, suggested to Sibongile that she should become an HIV counsellor. At that time the number of people aware of HIV in South Africa was still small. She advised Sibongile to learn more about this new disease and to go out into the community to inform people about AIDS. That year Sibongile completed a six month course

on HIV and AIDS at the hospital in Empangeni, Zululand. She visited schools and also taught *amakhosi* (chiefs) and *induna* (headmen) about HIV and AIDS. In the beginning Sibongile was quite nervous to talk about sexuality in the community. She knew that talking about sexuality was taboo. However, she considered it utterly important to inform people about HIV, therefore she believed the end justified the means. Initially people did not want to hear what Sibongile had to say, but over time they paid more attention. Despite her initial insecurity she walked around with condoms in her bag to hand out to people. Her sister had warned her that she would experience criticism and her sister was right. Some older people disapproved and criticised Sibongile that for a young woman her age she knew too much about sex. For those people who insisted on sexuality being a taboo topic, Sibongile's behaviour was hard to accept. The disapproval did not stop Sibongile. She wanted to protect her community and felt that speaking out about sexuality was needed to do so. She considered it her duty to bring knowledge about HIV to the community. Sibongile told people that if they had any questions, they could always come to her house. She recalls how at times her house looked like a clinic.

Sibongile got involved in HIV prevention during the early years of the HIV epidemic in South Africa. In these years people had only just started to hear about the epidemic. Yet the immediate stigma attached to AIDS caused people to avoid being linked to the disease. This made it hard for Sibongile to find people who were willing to listen to what she had to say. In her subject position of that of a Zulu woman it was regarded as disrespectful for her to speak to a man about sexuality. Hence when she went out to educate the *induna* and other men in her community, it was important for her not to speak as a Zulu woman, but as a professional. To emphasise her professional identity Sibongile wore trousers, addressed men directly, and kept eye contact. In the domestic field, however, such attitude had no place. Instead, at home her behaviour reflected the *hlonipha* rules, so she wore skirts, avoided eye contact, and avoided confrontation. Sibongile's strategic use of both progressive and conservative practices reminded me of the behaviour of Khethiwe. Sibongile became a trainer at 'Women and Children First' in 2003. Here she teaches staff members, overseas volunteers, community groups, and counselling students about HIV prevention. Even after hours, people still come to see her at her home when they need help and Sibongile continues to inform people about their risk of contracting HIV.

She recalls visiting some neighbours who were having an argument. Sibongile stopped the husband from hitting his wife. She took the wife to the side and spoke to her. Although the

wife was aware that her husband was sleeping with other women, she was not aware that this was putting her at risk of HIV infection. The wife told Sibongile that she had accepted the behaviour of her husband because she loved him. Sibongile informed the wife about HIV. She told her that she would not stay in such a relationship and that it was important to be selfish sometimes to live long enough to be there for the children. Later the husband came to Sibongile to apologise. She told him that he should apologise to his wife instead. Sibongile was aware that since the argument the wife had been sleeping in the children's bed, so she also told him that she hoped he was not just apologising because "his bed was cold". In her free time she does not only lecture her neighbours, but also the ladies in church. Sibongile attends the Lutheran church every Sunday. Here she speaks to the women about sexuality and HIV. She asks them to give her five good reasons why they would not have to use a condom. She also asks them if they trust their partners to be faithful.

It is surprising to hear that Sibongile speaks to her male neighbour like this. Her frankness does not reflect 'traditional' *hlonipha* practice, which requires her to show respect to men by remaining quiet. It is also surprising to hear how openly she speaks to the ladies in church, considering that historically it was Christianity that made sexuality into a taboo subject. Working in the health promotion field has taught Sibongile to openly refer to sexuality whilst talking to both women and men. She has also been taught to identify behaviour that increases an individual's chances of HIV infection and to confront individuals if this is the case. This knowledge has become part of Sibongile's habitus, her second nature, and it does not only shape her behaviour in the health promotion field, but also in the domestic field. Hence a transfer in knowledge takes place between the two fields. It seems as if she cannot help but speak out when she suspects someone is at risk of HIV infection. She told me: "We have to spread the gospel. We cannot leave any stone unturned".

Besides providing sexual education to other people's children, Sibongile also provided her own son with sexual education. She remembers that the first conversation with her son, Bheki, was slightly uncomfortable. She told him "if you have a girlfriend please come to me. It is very natural to love a person and to be loved, but please first come to talk to me, so that I can tell you about it". He asked "Mam, why do you have to talk to me about these things?" She told him "I always talk to people, why should I not talk to you? I should start with you before I go outside". After that first awkward conversation they started to speak more freely, as if they were brother and sister. Sibongile told him to first "check himself" [have an HIV test] before he enters any sexual relationship. Sibongile is very proud that her son is a blood

donor. This means that each time he gives blood, he gets checked for HIV. Although she has told him that she does not have to know, Bheki always shows his results to his mother, because he knows that she worries about it otherwise. As earlier information in this chapter has indicated, it is unconventional that Sibongile openly discusses the topic with her son. Although Sibongile is aware that 'traditionally' this has not been the way children learn about sexuality, she feels that her son does not have access to the correct information otherwise and she wants to protect him. Since she spends all day warning other young people about HIV, it seems only right to her that she also warns her own son. Sibongile's parents have never spoken to her about sexuality. As a result it is not part of the segment of her habitus that describes parent-child interactions. Yet, when it comes to discussing sexuality with family, she does have experience speaking about sexuality with her siblings and clearly she has a lot of professional experience in sexual education. Hence when talking to her son she combines these two segments of her habitus. This is why she mentioned that they speak as if they were brother and sister.

When Bheki brings friends home, he warns them beforehand about his mother's open behaviour. When his friends arrive she makes them sit down and she closes the door behind them. She tells them her name and asks them who they are, what their plans are in life, and if they have girlfriends. When Bheki's friends deny that they have girlfriends, she tells them that she does not believe them, because they are all "such pretty boys". This causes them to reluctantly tell her about their girlfriends. Sibongile then concludes the conversation by saying that they now know who she is and that if they have any questions, they can always come and talk to her. Some of Bheki's friends have indeed come to ask Sibongile for advice. Sibongile explains why she offers her help: "Our families are not open about sex. To talk about sex is already difficult for me. What about a person who is not me? Who is not working at 'Women and Children First'? I tell children: if your mother does not want to do it, come to me and I will tell you about it". Sibongile acknowledges that her involvement in the health promotion field has enabled her to talk openly about sexuality and she realises that many of her community members have not had this experience. Currently few adults provide adolescents with this much-needed sexual information. This is why she is making herself available to the young people in her surroundings both within her job and after hours. She is clearly 'sticking her neck out', as she is doing something that the majority of people in her community do not do. Yet she feels that she is not acting in a disrespectful manner as she is only doing it to protect her community.

The above has pictured Sibongile as a frank woman who seems to prioritise HIV awareness over Zulu customs. However the following paints a different picture. I asked Sibongile if she had also provided Nonkululeko (Sibongile's niece living in the house with her) with sexual education the ways she had done with her son? Sibongile explained that according to Zulu customs she was not the appropriate person to teach Nonkululeko about sexuality. It was not her 'duty', because she was not married and she was not the oldest sibling. As long as there were older people in her family, Sibongile was supposed to keep quiet. Even though she was "the counsellor", in the family it was not the appropriate way. She could offer her older siblings that she could do it if they wanted her to, but it would not be the "traditional" way. If there were any older people in the house she was not supposed to say anything.

Based on her earlier stories I had concluded that Sibongile spoke openly about sexuality to everyone, until she told me the story about her niece. In this story Sibongile suddenly refers back to "tradition" as the reason why she cannot talk to her niece about sexuality, yet on previous occasions similar 'traditions' had not stopped her. From her description however, this particular 'tradition' is a very clear boundary that she is unable or unwilling to cross. It seemed like a contradiction: when it considered her son the taboo could be overcome, but when it involved her niece it could not. Until I found out that when Nonkululeko had her first period she was sent to her paternal grandmother who still lives in rural Zululand. Here she underwent a puberty ritual. Nonkululeko had been vague about what exactly happened during this ritual. Sibongile explained that different families do it differently and that the girls are not allowed to speak about it upon return. Generally during this ritual, the girls are taught about protecting their virginity, about not falling pregnant before marriage, about STD's and recently also about HIV/AIDS. From watching Nonkululeko's behaviour and hearing her talk after she had returned, Sibongile could tell that her niece "understood".

Hence the main difference between talking to her son or her niece was that her son had not attended a puberty ritual, while her niece had. Sibongile has shown to be willing and able to overstep boundaries when she felt that there was a lack of HIV prevention information. With her niece, she did not have to. Nonkululeko had received information during the female puberty ritual and Sibongile had judged this to be sufficient.

The following section compares Sibongile's experiences to that of the other participants. It discusses whether the participants currently consider sexuality a taboo topic and what

contemporary sexual socialisation looks like. It also analyses if the participants transferred professional skills to their personal lives.

5.7.2 Contemporary ideas on the sexuality taboo

This historical overview has addressed in detail the complex situation around sexuality, going from being openly spoken about in the 19th century to a taboo topic in the 20th century when Zulu society adopted Christian morals into their way of life. I entered the area assuming sexuality was a taboo topic, not the least because when talking about my research in preparation to my fieldwork, everyone in New Zealand kept asking me how I would get the participants to talk about sexuality, suggesting that the participant would not be keen to discuss these matters. This resulted in my decision to approach the topic carefully when talking to the participants. In the field I was stunned to find Sibongile openly referring to sexuality during our informal conversations. Not much later, my indirect approach to the topic of sexuality led to the following frank response during an informal conversation with two men Thabo and Dingane (both 28 years old). Prior to this conversation some female colleagues had suggested that the girl visiting the NGO was Thabo's girlfriend. I was not sure if they were joking, so I decided to ask Thabo:

Eva:	Is she your girlfriend? (I am looking at Thabo)
Dingane:	She is a girl and a friend
Eva:	I would be a female friend
Thabo:	What is the difference?
Eva:	When you are girlfriend and boyfriend it involves actions
	(…)
Dingane:	Why are you not just using the word sex? You are scared to say this word. (Dingane is looking at me)
Thabo:	Did you enjoy the last time you had sex? (Thabo is looking at me)
Eva:	Can you even *remember* the last time you had sex, it has been such a long time ago, right? [Thabo had claimed a period of sexual abstinence during an earlier conversation]
Thabo:	Yes long time ago, maybe three months
Dingane:	Haha more like three days. I remember the last time, as we live together
Eva:	Haha
Dingane:	He will tell me that I have to stay out of the room for many hours. Maybe 8 hours
Eva:	You take that long? (I am looking at Thabo)
Dingane:	Go take a break and go again. Zulu men have sex when they wake up, after they have eaten, when they come home from work. All the time

This conversation failed to answer my question regarding whether the girl was indeed Thabo's girlfriend or not; a question that proved to be surrounded by much more secrecy than any questions about sexuality. The dialogue above shows that these young men had no problems discussing the topic of sex and they even challenged me to address the topic more openly. This turned out to be one of the many conversations about sex that I had with both male and female participants. I would argue that love and sexuality were their favourite topics and they would speak about this even when I did not instigate the topic. In this conversation Thabo keeps quiet, however Dingane brags about the libido of Zulu men, expressing a tough Zulu masculinity discourse.

This initial experience made the taboo around sexuality seem like it was no longer applicable. Later in the fieldwork it became clear that although the taboo was outdated in the health promotion field, in other fields it still heavily influenced the ability of participants to address the matter. So among each other and with me, sexuality could be openly discussed, but when the participants were talking to people who were not part of the health promotion field, especially if these people were older than them, they could not always be this open. Dingane and Thabo had the following experiences talking to older people:

> You would find that a 50 year old would be resistant to talk to you about sexuality. She would say: "You are far too young to talk about this, this is inappropriate".
> (Dingane)

> Younger ones in my family will come to me and ask me questions. The older ones will not do this, that is culture, culture, culture. They are not comfortable to talk to me about these things.
> (Thabo)

This shows that talking about sexuality in certain situations was still considered taboo. How could an older person ask a younger person for advice regarding sexuality when it had been conventional for the older person to give advice to the younger ones?

Sibongile mentioned that "our families are not open about sex" and the majority of the participants confirmed that conversations about sexuality between parents and children did not take place. These are some of the responses I received when I asked the participants if their parents spoke to them about sexuality:

> No definitely not. All I know about this, I know from myself. They did not talk about this.
> (Sduduzo, a 29 year old male)

> No they did not. I did not talk about this with my parents. Maybe a little bit with my brothers, but youth learn about this at school. Or they get the info at the clinic. Some parents are open about it. But not my parents.
> (Sibusiso, a 27 year old male)

> In my days, my parents would not talk about it. My father had told me that babies were being dropped out of planes. My mother had passed away and I asked my father if I could have a sister. My father took a sheet and ran outside. When he came back he did not have a baby. I asked him what happened and he told me that they only had boys.
> (Sizani, a 35 year old female)

Vukani mentioned that parents providing sexual education was considered a "White [western] thing" to do. The participants made it clear that the topic of sexuality was surrounded by silence and secrecy in the family home, something I observed in my host family where sexuality could not be mentioned or be seen, not even on TV. In an attempt to ensure that her children were not exposed to any images or information about sexuality, or at least not in her presence, my host-mother would change channels when the characters in 'Generations', a South African soap opera, started kissing. If she did not have the remote control in her hand, she would insist that her children changed the channel.

5.7.3 Parents who provide sexual education

This information shows that similarly to the practice of the 19th century, up until recently parents have refrained from talking about sexuality with their children. This was, however, not the case for everyone. There were also a few participants whose parents had spoken to them about sexuality:

> My mother does not talk about this openly, but my father, he will say things, like for example when I have this big box of condoms [to distribute into the community], he approves. He will say: "Good, you must distribute and you must use them". The only thing my Mam will say about this [sex] is: "Do not go there, do not go near the boys". In our culture it is awkward, you cannot speak about it freely. It is considered rude. But my father is modern about this. He can surprise you. With my sisters we talk about HIV, about everything. We have no secrets.
> (Sindi, a 25 year old female)

Sindi suggests it is surprising that her father speaks to her about sexuality, because it is not conventional in her "culture" for a father to do so. She states that by actually doing so, her father is being "modern". So Sindi considers talking about sexuality as 'modern' behaviour.

She is unaware that a century earlier it was conventional in her culture for people to openly refer to sexuality and that back then ‘modern’ behaviour referred to people avoiding open conversation about sexuality. This clearly shows that what is considered as ‘modern’ and ‘traditional’ changes over time and that foreign influences eventually become part of what is currently considered Zulu ‘tradition’.

Whereas with Sindi it was her father that decided to overcome the taboo in order to protect his children, with Cebilisile it was her mother who prepared her for her sexual debut by mainly warning her not to rush into anything. This does not mean that Cebisile and her mother could freely communicate about sexuality. Instead it was a one-time-only occasion for which she was taken aside from the other family members:

> I could not sit in the living room with my father there and say, “oh my boyfriend does not want to use a condom”. But my mother has come into my room to talk about it. She would sit down and tell me about the many protections you can use, because she does not want me in trouble. Some people think that if you talk about these things, it is like you are teaching them, suggesting it to them. The problem is my father. He thinks badly about this, but now he tries to understand.
> (Cebisile, a 24 year old female)

According to Cebisile it is currently still inappropriate for a child to talk about sexuality openly in front of his or her parents. She suggests that her mother broke the silence, because her mother wanted to protect her. Cebisile also mentions that her father is working on adapting his outdated views to the current reality.

Compared to Sindi and Cebilsile’s parents, Nolwazi’s mother seemed to have little difficulty with addressing the matter of sexuality to her daughters. She had noted a gap in the system which left her daughters vulnerable, so she decided to fill this gap herself:

> My mother, she was very strict, but she would talk to us about it. It was a bit strange to hear her talk about this, but she did. She would teach us how to behave. “Just wait”, was her main advice. “Nothing is running away. When time is right, boys will still be there”. My mother told us that we should not just say yes to the boys when they propose love to us. “Think about it. But you will feel it. There will be one person that feels right. I cannot explain to you what that feels like, but you will feel it. When you feel it, you should give it a try and see”. She would explain that when we get our period and when the boy “crosses the river at night in his dreams” [nocturnal emission] we would be able to make babies. So then it would be ‘dangerous’ to have sex.
> (Nolwazi, a 43 year old female)

Nolwazi's mother spoke in detail to her daughters about sexuality. She recommended abstinence and tried to empower her daughters to say no to boys, until they felt ready for such an experience. She also gave them practical advice for when they would start a sexual relationship:

> My mother also talked to us about *ukusoma* (intercrural sex). And I also did it. She would tell us that. "*Ukusoma* is about building a bond, building a relationship. Getting closer to each other. Showing the passion. It is to prevent pregnancy and to keep virginity, the pride of a young lady. At that stage you do not know if you will be husband and wife, so keep your virginity, maybe it does not work out. *Ukusoma* is also a way to keep him happy. If he does not get anything he might go looking elsewhere. This way he can show that you are his".
> (Nolwazi, a 43 year old female)

Nolwazi's mother was a Christian woman. In the historical overview it has been discussed how the practice of *ukusoma* vanished in the 1900s, after the church had branded it as sinful and the young men in town had branded it as "unfashionable and babyish playing". Yet in the 1980's Nolwazi's mother recommended this practice to her daughters. Nolwazi's mother gave her daughters all the information that the *amaqhikiza* would have given the girls in their groups during Mpande's time. Living in the township her daughters had no access to their grandmother, nor did they have a peer group system in place, so Nolwazi's mother stepped in herself to fill this gap and to make sure her daughters had the appropriate information to make informed decisions when approached by men.

Hence, the parents of this last group of participants were actually making the topic of sexuality discussable at home. The participants suggested that parents were slowly shifting their ways to respond to the current reality; a time in which sexual socialisation practices known from Mpande's time have mostly disappeared whilst HIV infection has become a serious threat. Whereas Sindi and Cebisile had reluctantly been prepped by their parents in the last 10 years, Nolwazi's mother already spoke openly to her daughters 30 years ago. The fact that Nolwazi's mother spoke more freely and 20 years ahead of Sindi and Cebisile's parents can be partially explained by the fact that Nolwazi grew up in the township, whereas the others lived in rural areas. According to the participants the people in the townships were less strict about following 'traditions':

> The mindset is changing. Now there are parents talking about sexuality with their children. It really depends on the area where you live. People in the rural areas are following the old rules. Whereas in the townships

> people talk more freely about sex. This shows in that when I was a counsellor and we would go to a rural area, let us say in the Greytown area. You would find that a 50 year old would be resistant to talk to you about sexuality. She would say you are far too young to talk about this, this is inappropriate. Whereas here in town, people feel more free to speak about these things with us.
> (Dingane, a 28 year old male)

Dingane described the Greytown area as a rural area in which people were still resistant to talk about sexuality. This was an issue that was actively addressed during the planning of a female *imbizo* (gathering of people) in 2010 on HIV prevention in Mbulwane, a rural area near Greytown. The organisers deliberated on how to set up the discussion groups. They wondered if they should divide the women into age groups, as they thought this would make it easier for the young girls to talk about sexuality and HIV. They explained it was still regarded as inappropriate for young people to talk about these issues in front of elders. Ultimately, the organisers decided to mix up the ages in an attempt to encourage intergenerational conversations about sexuality.

A shift to parental sexual education was very much welcomed and encouraged by the participants as they were convinced of the positive impact it would have:

> Parents do not talk about these things. They only start talking to you when you have already impregnated a girl. It would be good if parents talked about this. Our culture is very strict, so if we could make it part of our culture then I think we would do well.
> (Vukani, a 30 year old male)

> Those who do not get the information at home, will get the information elsewhere and this will possibly be the wrong information. So I think it should not be a taboo. The reality is that they [the youth] will start having sex at some stage. And without information this could lead to trouble. For many parents it is not easy to talk about this, so they [the youth] will get the info from their friends and the media.
> (Dingane, a 28 year old male)

> I think that now with AIDS and rape it is important to overcome this tradition and speak to our children openly about sexuality and HIV.
> (Sizani, a 35 year old female)

After establishing that the participants find it important that parents talk to their children about sexuality, I wondered if this meant that, like Sibongile, they themselves also spoke to their children about sexuality?

> I talk to them [her children] about pregnancy, STD's and HIV. I tell them: "you can talk to each other [someone of the opposite sex], but there should be no practice. Stay far away from each other, because if you come in contact with the virus you will be infected for the rest of your life".
> (Nolwazi, a 43 year old female)

> When I spoke to my daughter about sexuality, she told me: "Mam, I know, they have taught me at school". I think it is a good thing that schools provide sexual education, especially for the parents that find it difficult to address the matter.
> (Sizani a 39 year old female)

The participants either do already, or they intend to speak to their children about sexuality when their children have reached the appropriate age. Some, however, admit that they will struggle to do so:

> Hihi [giggling]. I cannot imagine myself talking to Ayanda [his six year old daughter] about this, but I guess I have to, who else will do it?
> (Thabo, a 28 year old male)

Even though Thabo is used to talking about sexuality at work, he feels uncomfortable just thinking about having such a conversation with his daughter. If it is difficult for an HIV educator to talk to his daughter about sexuality, then many parents are likely to struggle. What is agreed upon is that children need to be informed about sexuality. However, not all parents feel comfortable openly talking to their child about sexuality. The next section will discuss how these parents look for alternative ways to make sure their children have access to the appropriate information.

5.7.4 Providing sexual education without disrespecting the sexuality taboo

The above has shown that some parents have decided to openly talk to their children about sexuality, mainly because they found the stakes of not doing so too high. Yet the majority of parents who agreed that their children require sexual socialisation, still feel uncomfortable addressing this matter with their children. They look for a compromise in which they can ensure that their children are well-informed, without having to openly discuss sexuality with them. I argue that they employ one of the following three strategies to get their children informed. The first strategy is to make the conversation less awkward, by speaking to their

children as if they are peers. Another way in which they try to make it less awkward is by using metaphors to replace sexual words. Finally, when they simply cannot bring themselves to speak to their children, they look for someone to speak to them on their behalf.

5.7.4.1 Speak as if peers

As mentioned earlier, Thabo agreed that ideally he would have this conversation with his daughter, but he expressed the unease he felt just thinking about it. Parents are likely to feel slightly uncomfortable talking about sexuality with their children, because they do not have a template they can follow. Their parents have never spoken to them about sexuality, so it is not what they know as normal, it is not part of their habitus. They therefore apply the closest related segment in their habitus, for example the conversations they have had with their friends or their siblings, to find a way in which they can more comfortably facilitate the conversation. Sibongile for example stated that the conversation with her son was awkward to start with, but later they were talking like *brother* and *sister*. Although she could not copy her parents' behaviour, she had experienced how brothers and sisters spoke about this matter. She fell back on that template to ease the conversation with her son. Other participants mentioned:

> I talk to him [12 year old son] as if I am his *friend*.
> (Vukani, a 30 year old male)

> My child. I will talk to him or her. I would try to be like *friends* with them.
> (Sindi, a 25 year old female)

Traditionally it has been taboo for a parent to talk to their child about sexuality. To make the conversation less awkward these parents try to manipulate their subject position, instead of speaking as the parent to a child, they speak as siblings or as friends. This helps to level the relationship.

> People in the community will come to me. The older ones will say, "Please take me as your *brother/sister*, please take me as your age, take me as your *friend*". Because they want to ask me things that are normally inappropriate for us to talk about. They want me to forget about the rules, and to just tell them everything. They will then ask me to please not tell anyone.
> (Thabo, a 28 year old male)

The accepted norm would be for the older person in the conversation to be the one who speaks and advises and the younger one to listen respectfully. When it is the younger person

who has the information that the older person wants, common rules for interaction are compromised. The older person in this quote suggests fictive subject positions to allow for an exceptional interaction to take place. He suggests to ignore the age difference and instead to speak as 'friends' to level the relationship.

5.7.4.2 Avoidance of sexual words

A second strategy employed by the participants was the avoidance of sexual words. In this case, the use of metaphors instead of sexual words enabled them to have a relatively open conversation about sexuality. The following conversation provides a clear example of this.

While we had dinner at a restaurant, Nolwazi and Precious, both women in their early forties, talked to me about how to keep a man happy. They told me that 'leg over and chips' [sex] is more enjoyable for a man if there is more friction, which happens if the 'guava'[vagina] is dry. They explained that to keep the 'guava' dry, one must never wash it with warm water and soap. This makes the 'guava' soft and lazy. Instead one should wash the 'guava' with cold water, this makes it tight. When the 'guava' gets splashed with cold water it will get a bit of a fright. Nolwazi continued with a straight face that it [sex] is a normal thing and that it is a very important element in a relationship. A good relationship needs regular 'leg over and chips'. Nolwazi added that it is very important to keep the 'leg over and chips' with your partner interesting, to make sure it is nice for the man. This way he will not go looking for it somewhere else, and he will stay in an exclusive relationship with you.

These women were extremely forward in the matters they discussed around sexuality. Yet officially they had not spoken about sexuality at all, which means that their behaviour could still pass as respectful. The avoidance of certain words, because they would be considered disrespectful when used, is an adapted version of the *hlonipha* custom. Although previously the *hlonipha* custom had led to the avoidance of the entire topic of sexuality, more recently the *hlonipha* custom only avoided disrespectful words. By replacing the word sex with 'leg over and chips' and vagina with 'guava', it became possible for these women to talk about sexuality relatively openly. Mchunu, a Zulu researcher, used the same strategy when he spoke to his participants. He avoided the word sex, instead he spoke of *ucansi*, which translates to sleeping mat, but was also known to mean sex (Mchunu, 2005).

5.7.4.3 Arrange substitute to speak on the parent's behalf

Some parents were of the opinion that it was important that children had the appropriate information, but were unable to talk to their children themselves. They chose to ask someone

else to talk to their children on their behalf. Vusi, one of the participants, was approached by several parents from the young men in his soccer team. They asked Vusi to speak to their sons about sex and HIV. Vusi is not the only one who told me a story like this.

> When my older brother got this girl pregnant, my father told me to go and counsel my brother. "You go and talk to your brother. Just tell him".
> (Cebisile, a 24 year old female)

> My neighbours asked if I could please talk to their teenage children. They could see that their children needed information, needed to be made aware of things. But they themselves could not do this. So they asked me to do it. My mother tells me not to do it. She is worried that when I tell the girls to end their relationships, their angry boyfriends will come and kill me, but I do it anyway. I told them the facts; that sex is sex and the consequences of it.
> (Amukelani, a 32 year old female)

Even I was asked by a parent to provide her child with information. My host-mother asked me to talk to my 12 year old host-sister when she found out that our 13 year old neighbour was pregnant. My host mother was shocked and did not want the same to happen to her daughter, but she could not imagine having this conversation with her daughter. My host-mother knew what kind of work I was involved in, so she asked me to explain to her daughter how a woman gets pregnant and more importantly how to prevent pregnancy.

Vusi, Cebisile, Amukelani and I were known in the community and family as having knowledge on the topic, being trained to talk about sexuality and being aware of the concept of confidentiality. These parents see the need for information, but they feel that 'tradition' restricts them from actually speaking to their children. To ensure their children get the information, they ask the NGO workers to speak to their child on their behalf.

During Mpande's rule parents did not have to speak to their children about sexuality because, among other things, the *amaqhikiza* would do this for them. The *amaqhikiza* would make sure the adolescents had all the information and would behave accordingly. In my opinion Amukelani was being chartered as an appropriated *iqhikiza*. When I asked her if she was like an *iqhikiza*, she told me that it was not the same. Which is why I claim her role is based on the old custom, but updated to the current context.

5.8 Conclusion

The overview has demonstrated how prior to regular Western contact sexuality of the youth was closely regulated and monitored. The interaction with settlers and missionaries resulted in a gap in the system of sexual socialization. This gap widened in the eighties due to inter-generational conflict, political violence and an increase in migrant labour. This resulted in a lack in the system of sexual socialization in the years the HIV epidemic entered South African communities.

This chapter has attended to several persistent assumptions linked to 'tradition' and 'modernity'. My material has supported the work of authors like Eisenstadt, Wolf, Anderson, Spiegel and Boonzaier, who argue that 'tradition' is not static, not old fashioned, not resisting change, nor unaffected by 'modernity'. Whilst focusing on 'traditions' around sexual socialisation, this chapter has demonstrated that when 'traditions' became outdated between different historical periods, they were either adapted to better suit the social change, or they disappeared. This means that adapted 'traditions' are technically no longer the same as the 'traditions' practiced by previous generations. By starting the historical overview before colonialism the chapter has also demonstrated that so called 'traditional' societies were not static up until the settlers and missionaries arrived as often (indirectly) suggested.

The historical overview has also attended to the interaction between 'tradition' and 'modernity'. Although Zulu 'traditions' have been influenced by 'modernity', they have made 'modernity' their own by retaining some of their unique features. Hence Zulu 'modernity' is not the same as 'modernity' in Europe, or elsewhere. More recent HIV prevention literature argues for culture-sensitive prevention campaigns. Although this thesis supports this effort, this approach risks describing 'traditions' as static once again. If history is anything to go by, then it can be expected that Zulu 'traditions' will adjust again, this time to incorporate HIV prevention. Although it is important to design HIV prevention campaigns that are fitting to the local context, at the same time more credit should be given to the people 'on the ground', who are capable of responding to the suggested change in their own ways. This chapter has demonstrated how parents have appropriated foreign information and have implemented the elements they see fit in their own way. After establishing that there was a lack of knowledge among the youth, international campaigns recommended parents to talk to their children about HIV prevention. This campaign convinced parents on the urgency to get the youth informed about sexual matters. However, it did not necessarily lead to parents talking to their children directly. Instead most of them came to a compromise and found subtle ways in

which to implement sexual socialisation whilst still honouring the core of the custom. Similar to 'tradition', habitus has innovative capacity. Just like Bourdieu found that the Algerians responded "with creative reinvention to the discrepancy between the demands of the new economic rationality and their customary habits" (Swartz, 1997: 102), I found that the Zulu participants responded with creative reinvention to the discrepancy between demands of the HIV prevention campaigns and their customary habits.

This chapter closely described Sibongile's dilemma: was she to provide her niece with HIV prevention information or not? When in her position as community HIV educator in the health promotion field the habitus inclined her to speak about HIV openly to men, women, elderly and children. However, in her position as younger sibling in the domestic field the habitus inclined her to remain silent. Habitus shapes an individual's practice and it is not easy to deviate from. Yet individuals have choices. They evaluate the consequences of their behaviour; could they get away with acting unconventionally? The array of choices an individual has depends on the individual's capital and the position the individual holds in the field. Sibongile's lifestory demonstrates that Sibongile has on several occasions defied the expected behaviour because she prioritized HIV prevention over *hlonipha*. However each situation is different. It all depends on the interdependencies of the subjects involved. In the case of her niece, she could avoid acting outside the norm because her family had decided to provide her niece with sexual education through a 'modern' version of the 'traditional' puberty rituals.

Chapter 6: Initiating sexual relationships

6.1 Introduction

The previous chapter has described the relationship between parent and child and the information youth are given prior to becoming sexually active. It identified that there was a gap in the system of sexual socialization at the time when the HIV epidemic made its entrance into South Africa. This chapter discusses the initiation of sexual relationships and focuses on the relationship between men and women. It is important to describe this context in detail, because being aware of these underlying issues, helps to explain why certain HIV prevention campaigns are easier for the community HIV educators to implement than others, as will be discussed in chapter seven and eight. This chapter shows how habitus guides men and women in their gender specific roles and also attends to what extent gender inequality affects the ability of an individual to control practice.

Giddens (1992) describes 'modern' relationships in the west as 'confluent love'. These relationships are based on intimate equality, which is possible in a context in which men and women are both earning sufficient money and in which pregnancy can successfully be controlled. These relationships can exist without expectations or obligations and are therefore casually started and ended (Hunter, 2010: 198). This is in stark contrast to the majority of relationships in KwaZulu-Natal, which Hunter describes as 'provider love' or transactional relationships (Hunter, 2010). In these relationships a Zulu man provides money and goods, while a Zulu woman provides love and sex (Wickström, 2008). Hunter suggests that a Zulu woman chooses a man who has the financial means to pay for *lobolo* (bride wealth) and to set up a household. A Zulu man chooses a woman who can run a homestead successfully: a woman who works hard (*khutele*) and behaves respectfully *(hlonipha*) (Hunter, 2010: 44). In relationships like these, in which women are economically dependent on men, 'love' is above all a practical consideration (Hunter, 2010: 42; Wickström, 2008: 49).

This is an attitude that I also observed among my participants, which explains why instead of paying attention to the romantic side of love, this chapter mainly describes how 'love' is used by both men and women to accumulate capital. In the last two centuries marriage has converted 'love' into social, symbolic, and economic capital. Through marriage a man achieves a highly sought after and well respected position in the community, he acquires symbolic capital. At the same time a woman achieves both a worthy position in her community and to some extent financial security, hence she acquires both symbolic and

economic capital. However, in recent years, due to socio-economic changes, marriage has become harder to accomplish. This chapter demonstrates how, in response to this changing reality, alternative routes to continue the conversion of 'love' into capital have been invented. These alternative routes, including multiple concurrent relationships, place individuals at an increased risk of HIV transmission. Furthermore, by attending to these alternative routes this chapter will again address change and the fluidity of 'tradition' and returns to the concept of *hlonipha* to discreetly alter the normative rules.

6.2 *Ukushela* (to propose love)

As mentioned in the methodology chapter: When Mqondisi took me to Faras for the first time to introduce me to my host-family, he gave me the following advice: "Please make female friends. I do not mean that you cannot talk to men, but for friends it would be better to have female friends". This was the first time I was confronted with the fact that mixed gender friendships in Faras were unconventional. In the rural area it was uncommon to see a young man and a young woman 'hang out' together in public spaces if they were not family or not married. Subsequently, when I walked around Faras with a male participant we were stopped regularly and people asked him if I was his *makoti* (bride). One time when the participant replied that we were just friends an older woman told us, "*igundane alikwazi ukuba umngani nekati"*, meaning a rat cannot be close friends with a cat. When I asked the participants about this saying, they told me they had heard of a similar saying, "*ngeke ulishiye ikati negundane ndawonye*", which means you cannot leave a cat and a rat alone. Both sayings reflect the general viewpoint, also mentioned by Pattman in his work, "boys and girls should not be too close"(Pattman, 2005: 500). As a result members of the opposite sex are unlikely to get to know each other casually (Reeuwijk, 2009: 122). Instead when a man meets a woman that he is interested in, he will immediately *ukushela* (to propose love) her. This is not a marriage proposal, it is more like "an official declaration of interest" (Pattman, 2005: 502). In this section I will describe when, where and how *ukushela* usually takes place. Following on from the previous chapter, the focus will be on how *ukushela* has been adapted over the years to remain suitable in the contemporary context.

6.2.1 Setting

During Mpande's rule it was considered disrespectful to propose love to a woman in front of her family members (especially if they were male). This left only a few opportunities for *ukushela* because prior to colonialism, which among other things introduced church, school

and wage labour, women spent most of their time at the family's property (Harrison & Montgomery, 2001: 320). This meant that men had to wait patiently for the right moment in which they could approach the woman of their interest without being seen by her family (Hunter, 2004: 130). Several of the participants shared their elders' romanticised stories about *ukushela* that took place near the river or the forest where the women would go to collect water and firewood. When comparing this description to the present situation several changes can be identified. As has already been mentioned, the number of opportunities to talk to women while they are away from their family have increased. I observed men *ukushela* women in supermarkets, at social events or schools, and on the street. The following examples describe a few more places and the interactions that took place.

One morning on my way to town I watched a taxi driver *ukushela* a woman on the street while I was sitting in his taxi and he was driving around Faras to find more customers. The taxi driver suddenly stopped as he passed this young woman. He reached over to open his passenger's door and started to *ukushela* her. I could hear her protesting, but after some persistence on his part, she ended up giving him her phone number.

I also observed a female participant being *ukushela'd* while she was working. I joined Nandi for a day while she was working as a traffic controller in the centre of town. While keeping an eye on the traffic, Nandi told me about a few different men that were *ukushela'ing* her. First, there was the man in the shop next to the construction site. A week earlier, he had bought Nandi an energy drink when she had the flu, which made her feel much better. Although he was shy, she liked him for his caring character. They had exchanged numbers and he was proposing love to her through text messages. However, compared to the others he was not overwhelming her with messages. Second, there was a man who had walked past the construction site a week ago and had asked for her number. She had given it to him and he had been calling her ever since. He rang her at any time of the day, even in the middle of the night. I know this because it woke me up when I shared a room with Nandi. The second man came to visit Nandi the day I was with her. He offered to buy Nandi a new hairstyle. Furthermore, he told her that he was a born again Christian. Nandi questioned this as she had always understood that born again Christians were not supposed to *ukushela*. This man was very persistent in his approach. Although Nandi told him that she was not interested, he kept asking her to become his girlfriend. That night he was calling and texting her again. She sent him a text message in which she asked him to please stop contacting her. His response was to phone her immediately to explain once again that he really liked her and that he wanted her to

become his girlfriend. Nandi did not like him and she was worried that his visits at work might decrease her chances with Sphesihle, the man she was actually in love with. Sphesihle was her manager at the building site and he was the third man *ukushela'ing* her. When there was a storm one night Sphesihle had tried to phone Nandi to offer her a ride home in his car, but Nandi had turned her phone off because she was scared of the lightning. The next day Sphesihle was angry with her for not answering her phone. She thought it was very caring of him to offer her a ride. He had been discreetly *ukushela'ing* her at work. For instance the day I was with her, he rang her from the other side of the construction site, even though he could just walk over to talk to her. Later that day one of the workers offered us a bottle of Coca-Cola. Nandi told me that she thought it was coming from Sphesihle, but that he made the other person buy it so that it would not be too obvious. Nandi turned out to be right; Sphesihle later phoned her to ask if she enjoyed the Coca-Cola. Describing a day at work with Nandi highlights the opportunities for *ukushela* that arise when women go out to work. Nandi had three men proposing love to her just at work alone.

On another occasion I witnessed *ukushela* taking place in an HIV testing waiting room. Early on in my research I accompanied the receptionist at the 'Bafana AIDS Project'. This is when I witnessed a young man, who was waiting for the results of his HIV test, *ukushela'ing* a woman who was also waiting for her results. The way he approached her reminded me of what I might see in a night club, yet they were sitting in bright daylight waiting to find out if they were HIV positive or negative. Initially I was very surprised as it seemed out of place to me; later I wondered if it was actually a strategic move. In the current context in which HIV transmission is a considerable risk in sexual relationships, he might have increased his chances with this woman, because he presented himself as sensible, as a man who believed in the importance of knowing his status. This suggested that if she chose him, she would be safe.

One more location at which I experienced courting that stood out to me as odd was when I visited prison. This was one of the places attended by the 'Bafana AIDS Project' to provide mobile HIV counselling and testing. While setting up in the prison yard, one of the prisoners approached me. He asked me if I could see his friend out there. He pointed to the only white prisoner in the yard. He reckoned that the two of us, as I was the only white woman present, should get together. These examples show how *ukushela* is part of everyday life and the considerable increase in opportunities for *ukushela* since Mpande's rule.

Some of the examples above mention the use of mobile phones. The arrival of the mobile phone has created more opportunities to *ukushela* out of sight of family members or in

Sphesihle's case out of sight of his colleagues. In Nandi's example it shows how men use the mobile phone at any time of the day to convince women of their love for them. By overwhelming women with text messages and phone calls, they demonstrate that they are committed. This explains why the taxi driver insisted on getting the young woman's phone number. Besides allowing a demonstration of commitment, mobile phones can also speed up the process of *ukushela.* After obtaining a woman's phone number a man can easily contact her to set up a meeting, instead of having to wait for the next time, he coincidentally bumps into her again. Calling in the middle of the night was not uncommon. It woke me up every time I stayed with the participants and on several occasions even my own phone rang. To make a phone call from a mobile phone during the day was expensive. However, telecommunication providers put cheaper rates on after 8pm and free calls between midnight and 5am. As a result, the middle of the night was for many people the only time they could afford to call someone. It did not take long before the time of day of a phone call became a measurement of commitment and ability to provide. Women reasoned that if a man only rang them during the night, he was clearly unwilling or unable to spend money on them.

6.2.2 The script

Vilakazi wrote that *ukushela* was a "game which involves considerable skill" (Vilakazi, 1962: 47). Harrison added that *ukushela* proceeded according to 'socially approved guidelines' that were well understood by the youth (Harrison, 2010: 81). According to the rules of this 'game', women were expected to ridicule the men during their initial contact. Their sisters taught them witty remarks, which Vilakazi called 'verbal missiles', to respond to the advances made by the men (Vilakazi, 1962: 46, 48). At the same time young men were taught *kilela* (verbal trappings) by their brothers to entice the women to respond (Reader, 1966: 175; Vilakazi, 1962: 51). When women no longer ridiculed the men, but instead turned quiet and avoided eye contact, it was considered a sign that the men were making progress (Reader, 1966: 175). This could, however, take months (Hunter, 2004: 130). Despite practical changes over the years, *ukushela* still seems to follow socially approved guidelines well known by the youth. These guidelines are like an unwritten script. After comparing different observations, participants' stories, and my own experiences of *ukushela*, I suggest that a written version of the 'unwritten script' for *ukushela* looks somewhat like this:

Male: *Sawubona* [hello]
Female: *Yebo* [yes]

Male:	*Unjani*? [how are you]
Female:	*Ngiyaphila* [I am fine]
Male:	What is your name? And your surname?
Female:	My name is …
Male:	Can I please talk to you in private?
Female:	Why?
Male:	There is something I want to talk to you about
Female:	So speak
Male:	Are you married?
Female:	No
Male:	*Ngiyakuthanda* [I love you]
Female:	So you love me? Well then, tell me three things that you love about me [or another witty remark]
Male:	Can I have your number?
Female:	No
Male:	Why not?
Female:	I do not even know you
Male:	But I love you. So can I please have your number?
Female:	No
Male:	Why not?
	I want to be near you, so can I please have your number?
	I can provide for you, so can I please have your number?
	I would like to marry you, so can I please have your number?
	You are the only one for me, please can I have your number now?

This script illustrates that although practically the process of *ukushela* may have seen some changes, many of the morals established prior to colonialism have remained. First, it is still expected for a man to propose to a woman and not the other way around. When a woman likes a man, it would be considered disgraceful and disrespectful if she approached him directly (Ndinda et al., 2011: 4). She can, however, go out of her way to make that man notice her, so that he might initiate the *ukushela* process (Pattman, 2005: 503). At the start of this section I mentioned the Zulu saying: "*ngeke ulishiye ikati negundane ndawonye*" (you cannot leave a cat and a rat alone). In this saying the cat symbolises a man and the rat symbolises a woman. This fits the description of *ukushela*; just like cats chase rats, men chase women and not the other way around.

A second aspect addressed in this script that has remained the same is the request for privacy. Men often ask the women to walk with them to a place where they can talk out of

sight of the community. Although men no longer have to hide in the forest or near the river to get an opportunity to talk to the woman they are interested in, the participants noted that it was still considered inappropriate for a man to *ukushela* a woman when she was in the presence of a male family member. I recall one occasion in which a young man had thought of an excuse to call me away from my host-father, after which he *ukushela'd* me.

A final component addressed in this script which has not changed since Mpande's rule is persistence. Typically men try to convince women that they truly love them by being extremely persistent in their approach. The script portrays how a man repeatedly asks a woman for her number and how he continuously tells her that he loves her even though she hardly responds. Hunter writes how in the past it could take months of *ukushela* near the river before a woman gave in (Hunter, 2004: 130). Currently, it is still common for a woman to initially reject a man's *ukushela*. She is likely to only accept a man's advances when she is convinced of his love for her. When a woman eventually gives her number, the man might phone and text her several times a day, giving her compliments and telling her that he loves her over and over again. It is common for men to persist without getting any form of encouragement from the women. Men use this persistence to convince women that they are seriously interested. Van Reeuwijk (2009) found the same in her research with young boys in Tanzania. They told her that persistence was part of their strategy to pursue a girl. "The trick is not to give up (…) so that she will think that you find her special" (Reeuwijk, 2009: 102).

There are two more elements in this script that need explaining. The first one is the question about marriage. Marriage is generally regarded with a high level of respect. When it becomes clear that a woman is married, this usually results in a discontinuation of the *ukushela*. Merely having a boyfriend is not treated with the same amount of respect and does not seem to be considered a valid reason to stop the *ukushela*. The following is a conversation I witnessed between a taxi driver and a female passenger highlighting this matter:

Taxi driver:	I love you. Are you married?
Passenger:	I have a boyfriend
Taxi driver:	I do not care about your boyfriend. This is something between you and me, nobody else.
	So can I have your number?
Passenger:	No
Taxi driver:	But I love you. Can I please have your number?
Passenger:	No

Taxi driver: What must I do, must I stay alone for the rest of my life?

On another occasion a woman was told: "but your boyfriend does not need to know. I will not tell him. Will you?" This shows that the relationship status of boyfriend and girlfriend is not considered fixed like marriage, instead it still allows room for change.

The second element that needs attention is the vast promises made upon the first meeting (e.g. "You are the only one for me", "I want us to get married", and "I can provide for you"). During *ukushela* men tend to tell women what they like to hear, regardless of whether this is true or not. In their attempts to convince the girls of their dedication, they might promise things that they cannot afford or have no intention of actually doing (Reeuwijk, 2009: 103). One of the participants told me *intombi ishelwa ngamanga* (girls are proposed to by lies). As a result knowing what women want to hear is an advantage in *ukushela*.

6.2.3 *Ukushela* to express masculinity

The following examples consider whether *ukushela* is only worthwhile when a woman eventually accepts, or if there are also other reasons for *ukushela*. I was interviewing Nomsa in the back of a *bakkie* (pick-up truck) while driving down the motorway. She was facing the cars behind us whilst I was facing forwards. In the middle of our interview she was suddenly distracted by something happening behind me. When I turned around I saw a truck driver and his passenger using hand signals to *ukushela* Nomsa. This occasion left me wondering if men considered their chances before they *ukushela'd*. In answer to this question I suggest that the ultimate goal of *ukushela* is not always a woman's acceptance. On certain occasions a man's goal in *ukushela* could merely be to show his peers that he is comfortable talking to women. On this occasion *ukushela* is mainly a performance towards other men. Another example of this is when I visited a male circumcision clinic. As I walked into the waiting room, there was a group of 16 year olds waiting to get circumcised. When they noticed me, I could hear them chuckle among each other. Then one of the young men stood up and while being both encouraged and ridiculed by his friends, he *ukushela'd* me. It was clear that he did not expect that I would accept his proposal; instead his main motivation was to show his friends that he was brave enough to approach me.

So proposing love is sometimes more about impressing peers than about getting a woman to accept. Zulu men can prove their manliness by showing their peers that they are not shy with women and that they are able to get girlfriends. According to Hunter (2004), 'success' with women is a worldwide measurement of masculinity. Zulu men are no exception to this

rule; the status of *isoka* (a man popular with women) is desired, while being seen as *isishimane* (a man who is not successful in courtships) is feared (Hunter, 2004: 123, 131).

When persistence is not enough to convince a woman of their love, some men choose to use a particular *muthi* (medicine) called *umuthi wentando* (love medicine) to make a woman fall in love with them (Wickström, 2008: 54). Dingane explained that for this purpose there are two sorts of *muthi*. The first kind has to be hidden in a woman's meal. When she eats this *muthi*, she cannot help but fall in love with the man who put it there. The second kind is an ointment that is applied on a man's eyebrows. When a woman lays eyes on him, she will fall in love immediately. On both occasions she will not realise that it was the *muthi* that made her fall in love. Whilst Dingane was kind enough to explain this to me, the other men in the room were making fun of him. They suggested that Dingane needed *muthi*, to help him get a girlfriend. Dingane strongly refuted this. Among the men the use of *muthi* clearly represented a weak masculinity and was linked to *isishimane*. It was therefore not unexpected that none of the participants admitted to using *muthi*. Surprisingly, however, they were well informed about what *muthi* was, where it could be bought, and how much it cost.

Occasionally the male staff members at the 'Bafana AIDS Project' all *ukushela'd* the same female staff member. At times also I would be at the focus of their *ukushela'ing*. The way they were jokingly flirting with me was no different from how they approached the other females at the NGO. This *ukushela* was more about the competition among each other, than about them seriously wanting to start a relationship with the woman at the centre of their *ukushela'ing*. The competitive side of their approach came to light when the male staff members started to speak badly about each other to increase their own chances, as the following example illustrates.

Sibusiso:	I have good news for you.
Eva:	What is the good news?
Sibusiso:	I have decided that I want you to become my wife
Eva:	Oh ok
Sibusiso:	So do you accept?
Eva:	Uhm…. NO!
(others are laughing)	
Thabo:	You should not choose him. It is not safe, because he has not been tested. But you will be safe with me, I have been tested

In this example it is interesting to see how Thabo makes use of the health promotion discourse to make himself look better than Sibusiso. Similar to the man discussed earlier who *ukushela'd* a girl in the HIV testing waiting room, Thabo also used the safe and sensible discourse in his *ukushela*. On this occasion Sibusiso was losing the competition with his peers. However, on another occasion, as the competition continued, Sibusiso was bragging to the others that he had my mobile number. I thought he was lying, because I had not given him my number. The others asked me if it was true and I denied it. They then asked Sibusiso to prove it by phoning me. We all looked at my phone, and I was surprised when it actually rang. That day Sibusiso was winning the competition for which he received symbolic capital from his peers. Whether anything would actually happen between me and Sibusiso turned out to be irrelevant in this bid for masculinity.

6.3 *Ukuqoma* (to choose a lover)

The previous section has described how men *ukushela* women. This section looks at how women respond to these proposals of love and how they *ukuqoma* (choose a lover). In the following case study Cebisile shares how she and her boyfriend got together:

> I have been together with my boyfriend seven years. We got together while we were still in school. I remember how I was in love with him, but when he came to talk to me and proposed his love to me I told him, "I need time to think, ask me again in two weeks." After two weeks he asked me, "and?" I replied, "I need more time." He told me, "you can do research on me, you will find out that I am a good guy." A few days later I saw him with another girl. I felt jealous. When he came to talk to me, I was not smiling. He asked me, "what is wrong?" I answered, "I have a headache." He bought me some fruit and headache medication. I ate the fruit, but did not take the medication. He told me, "it is not your head that is hurting, it is your heart. Please tell me what is going on." I mentioned the other girl. He explained that there was nothing going on; he was just giving the girl back the pen that she had lent him. I was pleased with his explanation. Then one day I approached him and said, "there is something I need to tell you. Can we meet in the next free period?" He responded, "please tell me now." I replied, "no you must wait." Then he came knocking on the door of my classroom. He asked me, "so what is it that you have to tell me?" I told him, "I love you." "Wow" was his response. He hugged me and he lifted me up.
>
> (Cebisile, a 24 year old female)

When comparing Cebisile's response to *ukushela* with descriptions from earlier times, referred to as the Mpande era in the previous chapter, there are both similarities and differences. Back then young women were generally taught by *amaqhikiza* (girl of marriageable age in the role as peer advisor) about love, sex and how to respond to men's

advances (Raum, 1973: 285). The proper behaviour for young women was to initially decline and to ridicule the men who proposed to them (Harrison & Montgomery, 2001: 321). The *amaqhikiza* explained to the girls that men did not like women who gave in too easily, because it would have them worried that they would give in just as easily when another man proposed love to them (Varga, 2003: 163). Since then, many things have changed. It is no longer common to be guided by *amaqhikiza* and, as the previous chapter has argued, this gap has not sufficiently been filled by other forms of sexual education. Nevertheless, the above case study shows how Cebisile still played 'hard to get' even though she had already decided that she liked him.

Furthermore, in Mpande's time the women often took their time to do research on the men proposing love to them. They usually asked around in their network to get more information about the man's family and they talked to the herdboys and the *amaqhikiza* to get an idea of the intentions of the men (Vilakazi, 1962: 47). Although recently the route to information has changed, women still do their research prior to accepting a lover. I actually argue that this research has become more thorough since marriage has become less frequent and women have become more aware of men using lies to propose them with. This has caused women to become more sceptical. When a man says "I will provide for you", they might wonder if he really has that job or that rich family he claims to have. When a man says "I want to marry you", they might wonder if his intentions are serious or if he is just after some fun. Casual relationships are referred to as *jola* (just for fun with no long term plans) (Harrison, 2010: 82; Harrison et al., 2008: 304). According to Nandi *jola* is sometimes described as an acronym that stands for Jokes On Love Affairs. Moreover when a man says "you are the only one", they might wonder if it is true that he does not have other girlfriends. To judge his intentions, these women try to collect as much information as possible about their suitor. As part of his *ukushela*, a man might play on a woman's intentions to do research. This can be seen in Cebisile's case study. Her boyfriend invited her to do research on him and expressed his confidence that if she did, she would find that he was a good guy. By openly inviting her, he suggested that he had nothing to hide.

Hence the fact that women do their research has remained the same; only the way in which they gain their information has changed. Recently their social network has become extended to a large online network. This all started with a particular website referred to by the

participants as the 'toilet website'.[21] They used this website to find out if there was any damning information about a potential boyfriend, as this website provided a platform in which people would name and shame ex-boyfriends or girlfriends that had cheated in relationships. During my first period of fieldwork the time spend online by the participants was limited to the time they all sat around the single computer in the office that had internet access. During my second period of fieldwork many of the participants had switched to mobile phones with internet access. Facebook soon became another tool to do a background check. Girls would check how many female Facebook friends their suitor had and how he communicated with these women.

Besides the online research, some women also tested the men. Nandi told me about her strategy to find out if a man's intentions were serious. She told her suitor that she was 35 years old, that she had four children, all from different fathers, that she did not want any more children, and that she was looking for a man that would look after both her and her children. In reality Nandi was 26 and only had two children. If her suitor did not run away after hearing all of this, he passed her test.

When a woman's research has not revealed anything bad about her suitor and when she is convinced that he is serious and will ultimately be able to pay for *lobolo*, then she might choose to accept his proposal. She does so by saying the words: 'I love you'. Or at least these are the words used by the youth today. According to older sources, women used to say 'I accept you' (Raum, 1973: 284; Reader, 1966: 176). As part of his *ukushela* a man is likely to have said I love you many times, but this will be the first time that a woman will reply with the same words. When a woman uses these words, it signals the start of a relationship. This is evident in Cebisile's account. When she eventually told her suitor "I love you", he was very pleased and picked her up. This example is similar to Sduduzo's experience:

> I knew her from school, but I had never imagined that she would talk to a guy like me. One day, it was actually Valentine's Day, I was hanging out with the boys when she walked past. I went up to her and asked: "what did you get for Valentine's Day?" She replied: "nothing." So I told her: "if I was your boyfriend I would make sure you would always get something nice." I then asked her for her phone number and she gave it to me. I called her often and we would meet. Every time I spoke to her, either on the phone or face to face, I would tell her that I loved her. Even if we were talking about something totally different I would suddenly say "I love you." She never said I love you back. Then one day, when we were hanging out together and she

[21] www.nuwetoilet.wen.ru. This particular website has been closed since then, as it was slandering individuals.

> was busy typing something on her mobile phone, I received a text message. The message was coming from her and said: "I love you". I yelled out: "Hawu! You really love me?" "Yes, I do", she said. I then asked her: "does this mean I can have a hug?" "Yes", she said. "And maybe a kiss?" I asked. So then we kissed.
> (Sduduzo, a 29 year old male)

Sduduzo's relationship started when the woman of his interest sent him a text message with the words 'I love you'. This shows again how mobile phones have taken a central role in 'modern-day' courting practices. Even my own mobile phone became a tool in a courting ritual when it was used by one of the participants to *ukuqoma*. This happened when I was staying with Nandi. She asked me if she could borrow my phone to call Sphesihle, her manager, to let him know that we no longer needed the ride that he had offered us. During her conversation with Sphesihle I suddenly heard her say: "I love you". When I giggled, she looked at me with big eyes and she dropped the phone. She panicked and told me that she was not supposed to say that. She was worried about having to face him the next day and she planned to tell him that this was not what she had meant to say. Nandi clearly seemed unsure about her decision to say "I love you". Although a woman tries to find out if a man's intentions are serious, her research and tests do not give her any guarantees. Nandi's ex-boyfriends all lied to her. Despite their great promises they cheated on her with other women. She mentioned to me earlier that she did not want to start any more relationships, because she had her heart broken too many times. Out of the three boys that were *ukushela'ing* her, Sphesihle had convinced her that he would look after her. He had already started to do so by offering her rides home. She knew he had a good job and when he phoned her during the day he showed willing to spend money on her. Her research identified Sphesihle as her best option, however previous betrayal caused her to have her guard up.

The dynamics between a man and a woman generally change the moment a woman says 'I love you'. Her subject position changes from superior to inferior. During the *ukushela* period a woman can plainly state her expectations, she can negotiate the terms and conditions of a potential relationship, and she can openly challenge her suitor (Reeuwijk, 2009: 122). However, as soon as a woman has accepted her suitor as her lover, she becomes his; in a way he controls her (Varga, 1997: 55; 2003: 160). As of that moment it would be considered inappropriate if she challenged her lover. Instead she is expected to show him respect by keeping quiet. More on the expected behaviour of a future bride will follow later in this chapter.

Ukuqoma signals the start of a relationship between a man and a woman, however until the *ukucela* (formal betrothal) has taken place, the parents are not supposed to know about the relationship. A daughter hides the relationship from her parents to accommodate social expectations (Harrison, 2010: 81). Sindisiwe, for example, had been with her boyfriend for eight years, yet her father did not know that she had a boyfriend, she had only told her sisters and her grandmother. Although her mother seemed to know, Sindisiwe had never spoken to her about it. Sindisiwe did not want to introduce her boyfriend at home until he would do the *ukucela* (formal betrothal) and pay for the *lobolo* (bride wealth) in one go. Until that moment she planned to keep their relationship hidden for her father.

Before Cebisile's fiancée had done the *ukucela*, she also tried to hide the fact that she had a boyfriend:

> I would wait until everyone went to bed. Then I would sneak out on my tippy toes. I was sharing my room with my little brother, so I had to make sure I did not wake him up. I ran to my boyfriend's place, because I was too scared to walk. Maybe at three in the morning I would sneak back into the house. I remember how one morning my mother said: "I thought I heard something last night, did you hear anything?" I replied: "no, maybe you heard the mice." Then one night I must have woken up my brother, he told me the next morning: "I know you went out last night. I will tell Mam." I had to bribe him with candy, but I did not have enough money to keep up with his demands. So he ended up telling my mother. I told my mother that he was lying. One Valentine's Day, my boyfriend had given me a card, which I had hidden in my homework, but my brother found it. He showed it to my mother, who then told my father. Although I denied everything, he was very angry with me and ended up badly beating me.
> (Cebisile, a 24 year old female)

This anecdote shows how hard Cebisile tried to keep her relationship hidden from her parents; she bribed her brother and sneaked out at night to keep her parents from finding out.

Mobile phones have been mentioned throughout this chapter. The use of mobile phones during *ukushela* can speed up the process considerably. Instead of having to wait for a coincidental meeting, a suitor can talk to the woman of his interest over the phone, or he can arrange to meet with her via a text message. By using the phone he does not have to worry about being seen by her family members when talking to her. This means that he can contact her at any time. That is, if she gives him her number. By giving her number, a woman hints that she might be interested. Furthermore, a mobile phone is used by a woman when she does research on a potential lover. It seems that the mobile phone has made the mediating role of the herdboys and the *amaqhikiza*, mentioned in the previous chapter, redundant. In the rural

areas most internet use goes via mobile phones, so through her phone a woman can check out her potential boyfriend's Facebook profile to get clues about his personality. She can also assess his financial situation from his mobile phone use; the brand of his phone, the number of times he calls her, and the time of day he calls her (during the expensive rates or when it is free). When a woman has eventually decided on her lover, she might use her mobile phone to inform him of her decision if she is too shy to say the words 'I love you' out loud or face to face. Mobile phones also make it easier to secretly manage multiple partners. Having said that, several participants mentioned that it was the mobile phone that gave away the fact that their boyfriends had cheated on them. Overall, even though the mobile phone has only recently been introduced, it already plays a central role in initiating and maintaining sexual relationships. The use of the mobile phone has brought changes to the process of courting, but at the same time the morals of *ukushela* and *ukuqoma* have remained the same. It is merely a new way to play the same game.

6.4 Making the relationship official

When a couple has decided to get married they start the process of making their relationship official and the bride begins her *ukwenda* (long journey towards incorporation into her husband's family) (Krige, 1981: 4; Ngubane, 1981: 84). This section describes the 'avenues to marriage' (Malinowski, 1929). Besides the wedding, the couple is also expected to organise several ceremonies in the lead up to the wedding. This section demonstrates that altogether the journey to marriage is an extensive and expensive process (Hunter, 2004: 129; 2005: 395; 2010: 41). The information presented below is based on accounts of earlier anthropologists, information given to me by the participants, and my own observations in 2010 and 2011. The aim is not to deliver a one-fits-all description. Instead the aim is to show that over time and between couples there are many differences in the ceremonies performed as part of the wedding process (Krige, 1965: 133). This will demonstrate, once again, that 'traditions' are not static but dynamic and adaptable instead.

6.4.1 *Ukucela* (formal betrothal), *lobolo* (bride wealth), and gift exchanges

When a man and a woman (referred to as groom and bride from here onwards) have decided that they want to make their relationship official, the groom 'traditionally' approaches the bride's parents to negotiate the matter. This process is called *ukucela* (formal betrothal) (Krige, 1965: 124). Asking the bride's parents' permission to get married can be a delicate matter and cannot be done by the groom himself, because he is not allowed onto the property

of his in-laws until the couple is married. Therefore the groom usually appoints an *umkhongi* (negotiator) to lead the negotiation between the two families. The person selected as *umkhongi* is likely to be an older man who is known to be tactful and diplomatic and who has the groom's best interest at heart (Krige, 1965: 126; Reader, 1966: 179; Vilakazi, 1962: 62). Dumisani, for instance, asked the father of his best friend to be his *umkhongi*.

During one of our conversations Lindelani, gave me an example of *ukucela*. According to Lindelani *ukucela* typically happened early in the morning before sunrise. Upon arrival the *umkhongi* shouted out something like: "we are here for family X. Y has spotted a nice flower in your garden, we would like to talk." He repeated this three times. Then a boy would come outside to invite him in. The *umkhongi* had to sit on the floor and had to give the bride's family some money. Mandla, told me that he had to pay 2000 ZAR. Ulwazi mentioned that the price seemed to be increasing rapidly. According to Ulwazi in the "past" men only had to pay 100 ZAR, but when it was Ulwazi's turn in 2001 he had to pay 2000 ZAR and today he has heard about people having to pay 4000 ZAR. According to Vilakazi this payment was called the *imvulamlomo* (the mouth opener) (1962: 63). It would open the *lobolo* (bride wealth) negotiations.

It is usually also the *umkhongi* who will negotiate with the bride's family how many heads of cattle (or the equivalent in money) the groom has to give to the bride's parents. Knowing what the groom can afford, the *umkhongi* will try to negotiate the *lobolo* down to an affordable amount. Nevertheless, even with good negotiation skills, the amount will still be an enormous financial commitment. According to Nolwazi the bride is not directly involved in the *lobolo* negotiations, yet via her mother she can have some input. If she knows that the groom cannot afford it, she can plead with her mother not to ask for too much. Nolwazi suggests that in general, parents will be reasonable as they do not want their daughter to start her marriage in financial trouble. The 1869 Marriage Law fixed the vastly increasing *lobolo* price at ten head of cattle for a commoner, fifteen for an *induna* (headman), and twenty for an *amakhosi* (chief) (Atkins, 1993: 36; Carton, 2000: 40). On top of this, when the bride entered marriage as a virgin her mother would be given an extra head of cattle as a reward for protecting her daughter's virginity. This eleventh head of cattle was referred to as the *inkomo kamama* (mother's cow) (Xaba, 1994: 34). These days payment can be made in the form of cattle, the equivalent in ZAR, or a combination of the two.

Mandla, a truck driver for the local council who was marrying an unschooled unemployed bride and who lived in a rural area, told me that he was expected to pay two heads of cattle

and 15,000 ZAR. He suggested that a head of cattle costs about 4000 to 5000 ZAR. Thulani, a driver for the NGO who was marrying an employed bride and who lived in a township, told me that the family of his bride have asked a *lobolo* of 40.000 ZAR. The difference in the amount of *lobolo* asked for in these two cases could maybe be explained by the difference in income between Mandla and Thulani, the difference in earnings potential of their brides, the difference between living in a rural or an urban area, or a combination of these three factors. It has been explained to me by the participants on several occasions that *lobolo* should not be seen as buying a wife. Instead it symbolises the groom showing his appreciation to the bride's family for bringing up and looking after his bride for all those years. According to Ngubane *lobolo* indicates goodwill on the part of the groom's family. It shows that they treasure the bride and that they are in a position to support her (Ngubane, 1986: 13). Von Kapff states that it would be an insult for a woman to be married without *lobolo* (Kapff, 2011: 50, 51). This sentiment is confirmed by my host-father who also linked *lobolo* to a woman's pride. He said "a woman for whom *lobolo* has been paid can walk tall".

It is not only the groom's family who provide the bride's family with gifts. There are also gifts passing in the other direction. The bride's family bring gifts of food (such as pumpkin, maize, sugar cane, pineapples, bananas and sweet sorghum) beer, and household items (such as blankets, sleeping mats, pillows, pillow-cases, pinnies, towels, headscarves, pots, trays and tea sets), see Figure 19 (Bryant, 1949: 558; Krige, 1965: 133; Reader, 1966: 190). According to both Reader and Vilakazi the exchange of gifts between the two families was used to strengthen the relationship between the two families and these were paid for by the father of the bride (Reader, 1966: 207, 222; Vilakazi, 1962: 73).

Figure 19: Photo of the bride's family bringing gifts for the groom's family (By: E Maureau 2010)

The process of gift-giving is central to the interaction between the two families and makes for an interesting performance. By giving gifts the families express their respect to each other. However, the quality of the gifts is critically assessed by the people at the receiving end. If they are not up to standard they will be openly criticised. Mock-fights will follow, which ultimately will be resolved by gifting money. At one of the weddings I attended I observed this twice. First, when the bridal party arrived at the groom's property, the mother of the groom threw herself to the ground to block the path of the bride. She made it known that the bride's family could only pass if they put money in her hand. Later on, when the bridal party was presented with the head of cattle that would be slaughtered in their honour, the bridal party loudly complained that the animal was not fat enough. They requested a bigger head of cattle to be slaughtered and some money to apologise for the disrespect. Despite all the criticism and the mock-fighting, eventually the two families interact on a friendly basis.

It becomes clear that the ceremonies described above are concerned with bringing two families together. The gift giving ceremonies are all about the couple expressing their respect to their families and their ancestors. The road to marriage is not a journey of two people; instead it is bigger than these two individuals. In planning the wedding there will be many family meetings during which it becomes clear who is expecting what. Although the couple has the final say, it is questionable if this can be called individual choice. Their dispositions will be highly influenced by their family members. It is a collective effort.

Altogether the *imvulamlomo,* the *lobolo*, the bride's gifts, and the last minute peacekeeping donations add up to a great expense for the groom and partially also for the bride and this does not even include the actual wedding. Consequently, getting married requires a considerable period of saving, which is why *lobolo* demonstrates such dedication by the groom and why it can be considered a compliment to the bride. Additionally, it assures the bride (and her family) that the husband-to-be is able to save when it comes to important matters. Further along in this chapter it becomes clear that as a result of the high cost involved in getting married, marriage has become unattainable for young men who are unemployed or on low wages causing them to look for alternative ways to attain symbolic capital.

6.4.2 Something old, something new, something borrowed …

During my time in KwaZulu-Natal, I attended several weddings. Each of them was a Zulu wedding, yet none of them were exactly the same. Some weddings took place in one day, whereas others took place over a long weekend. In some weddings the bride and groom changed outfits several times; from animal skin and beaded outfits, to suit and a white gown, and back again. In other weddings the bride and groom wore a suit and a white gown during the entire event. Some weddings took place on the property of the groom's family, whereas others took place on the property of the bride's family with some including a visit to church whilst others did not. Furthermore, there was a difference in the demeanour of the bride. In some weddings the bride would act shy and lower her eyes throughout the entire event. In other weddings the bride was boisterous and smiling. There was also a difference in the rituals that were selected as part of the wedding ceremony. Sibongile expressed her approval of the wedding of her brother, which she described as a "proper" wedding because it included "all the 'traditional' elements". Her approval shows that this is not always the case. The bride and the groom, in negotiation with their families, make a selection out of the many rituals and symbols associated with weddings. These rituals and symbols have both Zulu and Western origins. Figure 20 shows the bride in a Victorian white wedding dress holding flowers whilst sitting on a chair (as opposed to sitting on the ground) in a *rondavel* (round hut) in front of a little altar with offerings where an older male family member burns *imphepo* (incense) to inform the ancestors that the bride is about to leave this family. As such Figure 20 is an image of 'multiple modernities' (Eisenstadt, 2000). 'Modern' influences were incorporated in 'traditional' customs and to keep 'traditions' relevant they were adjusted to contemporary circumstances.

Figure 20: Photo of the bride's family informing the ancestors that the bride is about to join a new family (By: E Maureau 2011)

6.4.3 Secret visits prior to marriage

Only after a couple is married, a man or a woman can be seen entering the property of their parents in-law. Until that moment they are officially not welcome. In practice this does not mean that they never enter the property of their future parents in-law. Chapter five already mentioned the secret visits at night (Raum, 1973: 287). To keep their relationship hidden from their family and thereby expressing their respect, a couple avoids displaying their affection when others can see them. For this reason they would avoid holding hands, romantic eye contact, and kissing in public (Mchunu, 2005). I observed similar behaviour in Faras when during the middle of the day I walked home with Mandla (my host-uncle) and Nomvula, a couple who had completed *ukucela* but had not yet paid *lobolo*. When we got close to Nomvula's house she turned off the main road and walked to her house. Mandla did not follow her, nor did he stop to say goodbye, give her a hug, or a kiss. Despite being officially recognized as fiancées, their behaviour in public could not be affectionate, nor could he follow her onto her property to, for example, hang out with her to watch some TV together. Instead Mandla came home with me to watch TV with his sister's family.

So when a couple cannot be affectionate in public and cannot spend time together at each other's homes during daytime, where do they go to spend time together? Cebisile told me that apart from visiting her boyfriend at his place in the middle of the night, she also saw her boyfriend at school. Furthermore, because he lived nearby, she phoned her boyfriend whenever her mother sent her to the *isitolo* (store) so that they could meet each other quickly

outside the store. Dingane mentioned that some of his classmates acted as if they were going to school in the morning, but instead met up with their girlfriends at the house of a friend where nobody was at home that day. This way they were able to spend time together without the family finding out about it. Furthermore, Nozipho told me that she would meet her boyfriend in town. Here he might book a room for the two of them, or they could use the room of a friend of his.

They knew they were not supposed to do what they did, however it was tolerated as long as they made sure they did it respectfully. Hence they had to avoid their parents being confronted with their inappropriate behaviour. They were practicing *hlonipha*; they expressed their respect by acting secretly. In chapter four I mentioned the example of telling my host-father of my home-visits to the male participants. Despite these visits not being of a courting nature, my host-father still considered the visits inappropriate. Looking back at it, I realise that the main problem was not the fact that I went to visit these young men, but the fact that I openly discussed this with my host-father. Unintentionally, I disrespected my host-father with my transparent approach. Contradictory to what I was brought up with, it was not transparency, but concealment that demonstrates respect.

Hence, despite the exact practices around courting changing over time, *hlonipha* has retained its significance. Although concealment was already part of sexuality under Mpande's rule, back then there were adequate practices in place to provide the youth with information whilst also monitoring their behaviour. More recently this guidance has faded away and the remaining concealment (secrecy around sexual activity) is placing the youth at an increased risk of HIV infection.

6.4.4 A wife's relationship with her in-laws and her husband

The night following the wedding is the first night that the *makoti* (newly married woman) is officially allowed to sleep with her husband on the property of her in-laws. During one of the weddings I attended it was pointed out to me how the next morning the *makoti* was put to work immediately. The *makoti* was expected to cook her first meal for her husband and his family, see Figure 21 .

Figure 21: Photo of the *makoti* cooking her first meal for her in-laws the morning after the wedding (By: E Maureau 2011)

Over the years her family had been preparing her for this moment. They taught her how to cook all the different dishes, how to do the washing and the cleaning, and how to carry water, wood and *mielie-meal* (maize meal) on her head. I was told that normally the *makoti* would live with her husband on the property of her family-in-law over the next few weeks or months. However, in this particular case the bride and groom both lived in Durban, and had only come out to the groom's family home in rural Zululand for the wedding. Instead of staying there for the next few weeks or months, they were only there for a long weekend after which the *makoti* would move in with her husband in his house in the city. During this weekend, however, the *makoti* worked hard to express her respect to her in-laws. She was doing the cooking, washing, cleaning, and fetching the water and the wood. In these few symbolical days she had to prove that she was not lazy in order to be accepted by her new family.

Subject to particular family rituals and the area in which the family lives, a *makoti* might be expected to adhere to any of the following *hlonipha* rules. A *makoti* should avoid making eye contact with her parents-in-law. She should avoid addressing them directly or pointing at them. A *makoti* should avoid touching the belongings of her parents-in-law. She should also avoid dressing improperly or eating in their presence. Furthermore, a *makoti* should avoid the *kraal* (animal pen) (Herbert, 1990: 457; Mchunu, 2005; Raum, 1973: 5). Another aspect of *hlonipha* is directed at the *makoti's* vocabulary. The main idea of this linguistic *hlonipha* is that a *makoti* must avoid the names of her in-laws in her speech (Carton, 2000: 69; Herbert, 1990: 459; Mchunu, 2005; Raum, 1973: 5; Rudwick, 2008: 155). To keep 'tradition' relevant

it has to adjust to contemporary circumstances. In the words of Rudwick: families "pick and choose whatever they want to have inside their *hlonipha* basket" (Rudwick, 2008: 166). The strict rules of *hlonipha* ease as the *makoti* is gradually incorporated into her new family.

There is a special 'release ritual' that marks the end of some, most, or all of the *hlonipha* rules (Herbert, 1990: 461; Mchunu, 2005). According to Herbert this often follows the birth of the *makoti*'s first child (Herbert, 1990: 461). However, at the wedding I attended the *makoti* underwent the release ritual after she had finished cooking her family in-law their first meal, just before she and her husband travelled back to Durban. This example demonstrates how 'traditions' are appropriated to contemporary circumstances to keep them relevant. By acknowledging the 'traditions', be it in an adjusted manner, this couple expressed their respect to their family members. This highlights the flexibility of 'tradition'. Furthermore, it once again highlights the significance of *hlonipha*; despite the fact that the couple lived a 'modern' life in the city they considered it extremely important to express their respect to their family in a 'traditional' manner.

After the wedding, a *makoti* can still be in contact with her natal family. However, in Mpande's time there was a rule that the *makoti* should not go home for the first three months following the wedding. If the *makoti* went home within this period, she would give her new family the idea that she was not accepting them. Currently, these rules are not as strict anymore, but it is expected that the *makoti*'s general loyalties lie with her husband's family. For example, from my host-mother I learned that when two family functions take place on the same day, the priority lies with the function of her husband's family. Furthermore, Sindisiwe told me that her sister who attended a different church than her husband had to join his church after they got married. It is expected of a *makoti* that she supports her husband in his responsibilities, that she is patient towards her husband, and that she does not challenge him. Instead, she should cook him his favourite meals and serve them to him on a tray, she should also ask her husband's permission to go out with her friends, and should not question his decision if he does not give her permission. The following advice was given by the bride's sister at a wedding I attended: "marriage comes with ups and downs. It is not always easy. When you notice that your husband is angry, you must not interrupt him. Instead you should reach down to your bag and offer him some chocolate". This makes it sound as if the wife's role is completely submissive. However, Nolwazi suggested that when a wife behaves in this respectful manner, there is room for her to share her opinion. She emphasised that it is not wise for a wife to be loud to her husband and to tell him that she has rights. Instead Nolwazi

created an equal relationship with her husband by acting initially in a submissive manner. This was how she showed her love for him, which created a peaceful and harmonic relationship in which her husband listened to her and supported her. Nolwazi's opinion is in line with Raum's findings which argue that as part of *hlonipha* a wife has to show respect to her husband, but a husband also has to respect her. He states: "observing respectful restraints results in a harmonious relations" (Raum, 1973: 1).

The above has painted a picture of the subject position of a woman in relation to both her in-laws and her husband. In both relationships she holds a submissive position, in which she is expected to remain quiet and not challenge any decisions made by her in-laws or husband. Yet it is in this position that international HIV interventions expect women to negotiate with their husbands, to suggest new practices, or more particularly to implement condom use. By describing the deeply ingrained role division between men and women, it is not hard to see the complications faced when attempting to implement these international HIV interventions. Gender inequality is part of the habitus and is actively passed on through discourse, as the above wedding speech clearly demonstrates.

6.5 Consequences of the inaccessibility of marriage

So far this chapter has described the ideal steps taken by a couple from the moment they meet, up until their wedding. This section takes a closer look at the meaning of marriage. It looks at the social, symbolic, and economic capital that both men and women accumulate through marriage and describes alternative routes to attain this same capital at times when marriage becomes harder to accomplish. This is relevant because at present it is not uncommon for young men to take between five to ten years to save up enough money to get married and for unemployed men marriage has simply become unattainable.

6.5.1 Capital acquired through marriage

For both men and women marriage is an extremely important and highly sought-after life event. For men, marriage is an important sign of masculinity. It is the first step towards setting up an independent household and becoming an *umnumzana* (respected head of the family), a desired status that enforces admiration in the community (Hunter, 2004: 124; 2005; 2010: 53). Marriage is an important rite of passage towards manhood. I witnessed the ceremony that informs the community that the groom is no longer a boy, but that he has become a man instead. This happened during the last day of the wedding. The groom had invited all his male family, neighbours and friends to join him in the *kraal* (animal pen).

Together they ate the head of the cow that the groom's family had slaughtered the day before and they drank *utshwala* (sorghum beer). After the meal the groom initiated a dancing session. With this ritual the groom established himself as *umnumzana* in the community, a position that comes with symbolic capital. A woman also accumulates capital upon marriage. Despite her initial submissive status as *makoti*, a married woman gradually gains status, importance and influence in her new family. The same happens in the larger community; upon marriage a woman gains a voice and a position in which she can influence certain matters in the community, she accumulates symbolic capital (Hunter, 2010). Furthermore, marriage provides a woman with a certain level of financial security as a husband is expected to provide to the best of his ability for his wife and the children they might have. Hence, through marriage a woman also acquires economic capital.

6.5.2 Financial hardship causing a delay in marriage

This chapter so far has described the many steps involved in getting married which over the years has become more and more expensive. For men who do not have steady jobs, or who earn low wages, it takes a long time to save up enough money to pay for *lobolo* and the other costs involved in the extensive procedure leading to marriage. At present it can easily take ten years before the extensive process has been completed. Dumisani, for instance, has already been in a relationship with his girlfriend for eight years but has only started the *lobolo* negotiations recently. Mandla has been in a relationship with his girlfriend for seven years and although he has completed *ukucela*, he has not finished paying the *lobolo* yet. Thulani has been with his girlfriend for five years and has so far only paid half of the *lobolo*.

Prior to the wedding a couple has been expected to practice only *ukusoma* (intercrural sex) (Buthelezi, 2006: 4; Krige, 1968). This expectation becomes hard to live up to when more recently it takes so much longer to complete the procedure towards marriage. Chapter five briefly mentioned how in 1915 King Solomon kaDinuzulu married Christina. For him it was easy to adhere to this rule. When he met Christina he knew immediately that he wanted to marry her and he had sufficient resources to pay for *lobolo*. So the second time he saw her was when he picked her up for the wedding ceremony (Hourwich Reyher, 1948). However, in the contemporary situation of financial strain most couples do not get married on the second day they spend together and it is hard to imagine that a couple would refrain from sexual intercourse for the ten years it might take them to save up for the complete event. Consequently, an increasing number of couples have penetrative sex prior to marriage and therefore also have children prior to wedlock (Hunter, 2010; Loudon, 1970). Mandla and

Nomvula, for example, recently became parents, without being married. Surprisingly, to me, Mandla and Nomvula did not live together despite having a baby together. Furthermore Mandla did not visit Nomvula at her house when her parents were likely to see him there. When he did visit Nomvula and the baby he hid in her room. Mandla and Nomvula's story shows that having a child together does not ease the rule that a person is officially not welcome at the property of their in-laws prior to the wedding. Mqondisi's story is similar. Despite not having completed all the steps towards marriage, he and his fiancée already had two children, yet they still lived with their respective natal parents. The two children spent time at both houses. I joined Mqondisi one day when it was time to take the children back to their mother. We walked the children over together, but we stopped before we got to her house. Mqondisi rang his fiancée and asked her to walk into our direction. Mqondisi and his fiancée acted in a distant manner when Mqondisi handed over the children. They did not want to pose together in a picture when I asked them to and we soon continued our walk. Mqondisi explained to me that officially he was not allowed to go onto his fiancée's property until the day they got married. This meant that he only visited her when it was dark, when her parents were away, or they would meet up away from the property like we had done this time.

The fact that Mandla and Mqondisi were not cohabitating was not the exception but the rule in the rural area. I attended one wedding of a couple in their fifties. They had been in a relationship for the last twenty years, but it was not until the wedding day that the bride moved in with the groom. In fact, in Faras I did not meet or hear of any couple who lived together without being married. Urban areas, however, have seen a relaxation of this rule. I know of two cohabitating couples who live in the townships around Durban. Similar to some of the examples in the previous chapter this emphasises the difference between how customs are practiced in the rural and the urban areas.

As has been mentioned earlier, as part of *hlonipha*, unmarried couples have to make sure that their parents are not confronted with their sexuality. Pregnancy, as a visual sign of an active sexuality, has therefore been considered disrespectful towards the parents. However, due to the changing circumstances, parents have started to condone pregnancies prior to marriage under certain conditions: the couple has to be in the process towards marriage, the father has to be willing and able to provide for his child, and to maintain their dignity the couple has to make sure to express their respect towards their parents in every other way. Hence, when a couple deviates from the ideal by falling pregnant prior to marriage, this does not mean they give up on ideal behaviour altogether. Instead it becomes extra important for

them to show that they know how to express their respect. This is in line with Mchunu's argument that although rules have been relaxed, an effort is still made not to disrespect elders (Mchunu, 2005). This means that despite having a child, a couple still adheres to other ideals; they do not cohabitate, they do not visit their partner at home whenever they please, and they do not display affection for their partner in public. Mchunu explains that by avoiding affectionate behaviour in public, a son would maintain his father's dignity, as it suggested that his father had taught him how to behave respectfully (Mchunu, 2005). Hence when individuals deviate from the ideal, they are encouraged to do so as respectfully as possible. I refer to this as 'discreet indiscretions', a term borrowed from Bergmann who uses it in relation to gossip. Inappropriate behaviour can be condoned when it takes place in a discreet manner (Bergmann, 1993). Although Mandla and Mqondisi's situation was not ideal, it was condoned because, besides their pregnancy, their behaviour was respectful.

6.5.3 Alternative ways to express masculinity

The previous description has presented a group of young men who, despite experiencing some delay, still end up marrying and therefore becoming *umnumzana* and achieving their status as senior men. There is, however, also a group of mainly unemployed young men for whom marriage has become unattainable. This means that these young men cannot become *umnumzana* and that they do not receive the symbolic capital associated with this status. This second group is no longer an exception. Hunter argues that in his research area weddings had become rare events (Hunter, 2005: 395), whilst Mindry states that marriage in South Africa has become a middle-class phenomenon (Mindry et al., 2011: 590). These young men struggle with their masculinity and look for alternative routes to prove their manliness. They have found this in the concept of *isoka* (a man who is popular with women). As part of this masculinity men aim to show their peers that they are desired by women. As the following section will explain, amongst these young men, fathering a child or having multiple partners is considered evidence of being desired by women. Having multiple concurrent relationships has been identified as a great risk factor to HIV transmission and this will be illustrated at the start of chapter seven. The risk is particularly high when having unprotected sex, which is obviously the case for those who attempt to father a child.

6.5.3.1 Fathering a child

Hence, fathering a child is one way to display sexual virility (Hunter, 2010: 170). It portrays a man who is not shy with the women and who is able to get a woman to have sex with him.

Vusi, who had five children outside wedlock with five different women, told me that when he was nineteen, a common thought among his peers was that a man was not cool if he did not have a child. Vusi's situation emphasises that being able to provide for the baby is hardly considered in this context, an idea also observed by Klugman (1990). All of Vusi's children live with their mothers, and none of them carry his surname, because he has been unable to provide for them.

Trust is a central concept in the negotiation that takes place between a couple prior to having sex. A woman has to be convinced that the man she is about to have sex with does not merely choose her for a *jola* (casual) relationship, but is ready for a serious commitment. At the same time, she feels the pressure that she cannot take too long to figure out his intentions, because eventually, if she did not give him what he is after, he would lose interest and end the relationship. When she eventually agrees to have sex with him she shows commitment to her partner. It is a "marker of trust" (Varga, 2003: 160).

As discussed earlier in this chapter, men worked hard to convince women they were serious, even if they were not: *intombi ishelwa ngamanga* (girls are proposed by lies). The following will present two stories, one of Nandi and one of Wandile. Nandi was seduced by lies twice by the same man and fell pregnant on both occasions. It describes the uncertainty in relationships from a female point of view. Wandile's story is that of a man in desperate search for approval and shows how, by having a child, he both gained and lost capital. This is different from the situation of Mandla and Mqondisi, because in the case of Nandi and Wandile these were not pregnancies prior to marriage, but instead were pregnancies without marriage.

Nandi found out the hard way that her boyfriend actually never intended to marry her. Convinced of the seriousness of their relationship, Nandi had sex with her boyfriend and she fell pregnant. Her boyfriend did not provide for the baby. He told her he could not help her with the baby because he did not have any money. He went to Durban to train as a policeman. When he came back to visit her, he made it sound like he was finally able to provide for Nandi and their child. They ended up having sex again. The next morning Nandi found a message on his phone in which he explained to some other woman that Nandi meant nothing to him, that she was only the mother of his child. Nandi was very hurt when she found this message. She told him that it was over between them. He tried to convince Nandi that he only sent that message because the other woman was unwell. Nandi did not want to hear it. Later she found out that she had become pregnant again. This time she did not even bother asking

him for money for his children. However, when she lost her job a few years later, she approached the father of her children because she desperately needed help. Again he told her that he could not help her. This time his new girlfriend had just had a baby, which took up all his resources. Nandi was left to provide for her two children by herself.

After graduating from high school Wandile had been unable to secure a job. Wandile had a girlfriend, but he had no long-term plans for their relationship. This did not change when she fell pregnant. Instead he fell in love with another woman. Wandile was not officially acknowledged as the father of the baby, because he was unwilling and unable to take responsibility. Wandile had no money to support the baby or to pay *inhlawulo* (damages) to the woman's family. Paying damages essentially requires a man to pay the head of cattle that the mother can no longer receive as part of the *lobolo*, because her daughter is no longer a virgin (Ndinda et al., 2011: 8). By having the child Wandile commanded admiration from his male peers. He had provided visual evidence of his ability to talk a woman into having sex with him. By doing so he showed off his manliness. However, unlike the pregnancies caused by Mandla and Mqondisi, Wandile's family did not condone the pregnancy caused by Wandile. Whereas Mandla and Mqondisi were engaged to their girlfriends and contributed financially to raise the children, Wandile's relationship with the mother of his baby had ended and he was unable to provide her with any financial support for the baby. He embarrassed his family by having sex prior to establishing a serious relationship and bringing a child into this world that he was unable to care for. With his actions he had disrespected his former girlfriend, her parents (who now had another mouth to feed) and his own family. Interestingly enough, Wandile himself was also born out of wedlock. His parents' relationship did not lead to marriage. His father never provided economic support and has since passed away. His mother eventually married another man. His stepfather did not accept Wandile into his family, so Wandile was left behind with his mother's unmarried siblings. Upon marriage his mother became part of the financial unit of her husband and his family and she was not allowed to support her son financially. Her son found himself in a betwixt and between position, struggling to find approval. His recent involvement with alcohol, violence and the pregnancy was anxiously followed by his mother, yet her husband kept her from intervening. In response to Wandile's disrespectful behaviour, his stepfather supported him even less than he had done previously. Hence as a result of his actions Wandile lost symbolic, economic and social capital.

Despite Wandile's situation being frowned upon, his situation was not rare. Of the eighteen participants in this study that had children, only three were married and five were in the process of getting married when they had the baby. The other ten had children without continuing the relationship. This portrays a trend of unsafe sex taking place in uncommitted relationships, which is clearly an HIV transmission risk. It describes how for many young men the priority lies on impressing their peers, whilst for many young women the priority lies on finding a man who lives up to his promises. It has painted the picture of women as naive, but instead of naive I argue that their behaviour is the result of gender inequality. To support this argument I later on attend to several examples of women's strategic practices to influence their situation to the best of their abilities.

6.5.3.2 Multiple concurrent relationships

Another way in which men tried to make up for their inability to get married was by showing off to their peers that they had multiple partners. I regularly observed unmarried men boast about the number of girlfriends they supposedly had. Hunter argued that in times when young men could not afford to get married and achieve the highly respected status of *umnumzana*, celebrating numerous sexual conquests was an important way in which men could prove their masculinity (Hunter, 2005: 389, 397). It was important to become known as *isoka* (a man popular with women). At the end of the 1800's *isoka* meant a man who was popular with the girls (Hunter, 2004: 130). In the 1940's *isoka* referred to a man who had multiple sexual partners. However, it was still expected that eventually he would marry each partner, so he could only have as many partners as he could afford to marry (Hunter, 2004: 131; 2010: 53). From the 1970's *isoka* came to mean a man who has many girlfriends and he was no longer expected to marry any of them. The current meaning of *isoka* is a play on polygamy. Recently a man who has multiple girlfriends receives the same amount of respect from his peers, as the respect a man previously received upon marrying multiple women (Hunter, 2004: 125; Mulwo et al., 2009: 316).

It was the month's end, which meant payday at the NGO. I met up with a group of male staff members in town after work. They had decided to *braai* (barbeque) some meat. During the meal the men talked about the importance of having more than one girlfriend at any one time. This was one of many conversations I witnessed which suggested that it was desirable for a man to have multiple partners. During these conversations I was provided with the following reasons why men had multiple girlfriends: to keep the sex life interesting, to do women a favour as there were supposedly more women than men, to explore different options

to find the right woman to marry, to make the main girlfriend jealous so that she worked harder to impress, and as a back-up so that when a relationship ended they were never left without a girlfriend.

All these conversations suggested that it was simply considered the norm for men to have multiple partners. The way both male and female participants reflected upon my personal situation stressed this idea. When they found out that I was away from my partner in New Zealand for eight months, almost everyone responded that my boyfriend was definitely getting 'it' elsewhere. The female participants apologized after they realized what they had said and tried to play it down by reassuring me that my boyfriend was probably different from the men they knew. However, the male participants stayed with their initial response and jokingly suggested that if my boyfriend was sleeping with someone else, I should do the same. Throughout the fieldwork many of the female participants told me about their experiences with cheating boyfriends, fiancés, or husbands. One in three men in the research conducted by both Harrison and Mulwo reported having multiple partners, which forms a high risk for HIV transmission (Harrison et al., 2008: 295, 297; Mulwo et al., 2009: 312).

Similar to Pattman (2005) and Harrison et al. (2008), I found the overt boasting that took place when young men were among their male peers to be in stark contrast with the covert discourse men chose in other company. This becomes evident when comparing the following two conversations I had with Vusi. This first fragment comes from an informal conversation that took place between Vusi, his male peers, and me:

> One girlfriend is not enough, because she might not want to have sex with you or she could be cheating on you. For this reason you should always have more than one girlfriend. I once had a coloured girlfriend, she left me when she found out that she was not my only girlfriend. Coloured women do not like this, but many Zulu women do not mind it when you have more than one girlfriend.
> (Vusi, a 31 year old male)

However, when the topic of multiple partners came up during a private interview, Vusi told me:

> I think having one partner is the best way. Having two does not work. That is no faithfulness. I think love is only one. The heart can only love one. I think one should have one girlfriend, one wife, and work together. Also economically this is more interesting. If you have a second girlfriend, you are hiding it. This means you are lying to your girlfriend and then you are feeling guilty about that.
> (Vusi, a 31 year old male)

Despite often hearing the male participants boast about the importance of having multiple girlfriends and hearing numerous stories from the female participants about cheating boyfriends, when I asked the male participants in private interviews if they themselves had multiple partners, none of them confirmed this. They only spoke about having multiple partners when reflecting on their past behaviour. They presented themselves as changed men who knew better than to have multiple partners. The following fragments show this:

> In the past I have had many girlfriends. But now I have changed.
> (Thabo, a 28 year old male)

> During Matric almost all of us, including me, wanted many girlfriends. There were very few who were strictly religious and wanted only one. But as life goes on, this changes. It was a struggle to get and keep many girlfriends. It was expensive and stressful.
> (Sibusiso, a 24 year old male)

I have observed the same person claim different things in different settings. More interesting than choosing one of these as the true statement, is to study what it means that this person presents himself in different ways. His narrative changes in different company. He tunes to his audience and clearly accommodates to social expectations (Harrison, 2010). When he is among his peers he boasts about his numerous sexual conquests. His aim is to gain the respect of his peers and this requires such behaviour. However, when he talks to me, the researcher, he anticipates more respect is to be gained if he presents himself as someone who has learned from his mistakes and who has now chosen a monogamous lifestyle. In this discourse he mentions multiple partnerships only as part of his past behaviour. Hence, when the norm suggests that having multiple partners is acceptable and even desired, then multiple partners are overt in their discourse. If the norm suggests that multiple partners are inappropriate, then the habit of multiple partnerships are covert in their discourse. In the latter instance secrecy is encouraged. Unfortunately, it is this secrecy that increases the risk of HIV transmission. The fact that it can take several years before couples move in together makes it easier to maintain multiple concurrent relationships as couples have less opportunities to monitor their partner's behaviour. When a couple's relationship status is not publicly acknowledged it is hard to tell if someone is already in a relationship with someone else.

6.5.4 Financial hardship causing women to have multiple concurrent relationships

Men were not the only ones who resorted to multiple relationships at times when marriage was hard to achieve. There were also women who took on multiple relationships in response to the financial crisis. Hence for both men and women the practice of multiple partners was "contested on the ebb and flow of changing material livelihoods" (Hunter, 2005: 400). One in four women in the research conducted by Mulwo reported having multiple partners (Mulwo et al., 2009: 312). It was only near the end of my fieldwork that I became aware that some of the women I worked with had multiple partners too. Women distinguished between their main partner and their secret partners. The main boyfriend was the public boyfriend. He was the boyfriend who was most likely to start, or had already started, the process towards marriage. The secret boyfriend was not necessarily a casual lover; instead their relationship was often long-term (Harrison et al., 2008: 295, 304). Once the main boyfriend started to pay *lobolo*, which was considered a sign of commitment, he was referred to as fiancée and this often resulted in the woman ending the relationships with her other boyfriends (Hunter, 2010: 190-192). The women called their secret boyfriends *makhwapheni* (under the armpit) or 'roll-ons', which referred to deodorant. Both names described how these boyfriends were hidden from public view (Harrison et al., 2008: 295; Ndinda et al., 2011: 5; Varga, 2003).

I have identified several reasons why women choose to have multiple partners. The first reason was because women wanted to increase their chances of getting married. Women were aware that during the *ukushela* (proposing love) men often promised them marriage without being able to follow this through due to a lack of funds. In response to these empty promises, some women decided to keep their options open to see who actually followed through their promises. Ntokozo, the receptionist at the 'Bafana AIDS Project', seemed to fall into this category. Nandi told me that Ntokozo and Vusi had been a couple. I was surprised to hear it, because I thought everyone in the team knew that Vusi was an *isoka lamanyala* (a masculinity gone too far) (Hunter, 2004: 132). However, Nandi explained that Ntokozo had only just joined the team and had not heard about this yet. Vusi was spoiling Ntokozo with gifts and told everyone that he was a changed man who had finally found the woman that he wanted to marry. I expected Nandi to tell me that Vusi ended up breaking Ntokozo's heart, but Nandi explained that it was actually the other way around. Ntokozo broke up with Vusi when her other boyfriend started to pay *lobolo* for her. Both boyfriends had been promising her great things, but it was her other boyfriend that followed through his promises and

thereby showed Ntokozo that he was truly committed. Now that she felt confident that she was getting married, she was no longer in need of two boyfriends.

A second reason for women to have multiple partners was to gain economic capital. A married woman experienced financial security, because her husband was expected to provide for her and the children they potentially had together. Hunter refers to this as 'provider love'. However, in recent times when the prospects of marriage are small, Hunter argues that "men have moved from being providers within marriage to less reliable and less esteemed providers outside of marriage" (Hunter, 2010: 190). Although a boyfriend supported this girlfriend with gifts, this was not always enough to make ends meet. To accumulate more gifts some women choose to have multiple boyfriends. For some women this was a matter of survival. From their different boyfriends they received gifts like food, rent, school fees, and transport money. Other women were involved with multiple men to gain access to consumer goods. Their boyfriends gifted them handbags, mobile phones, clothes, cosmetics, and new hairstyles. The fact that these women referred to their 'roll-ons' as 'Ministers' of finance, transport, or education, emphasised how money was a motivating factor for these additional relationships (Selikow, Zulu, & Cedras, 2002: 26). These relationships are often referred to as transactional, Hunter points out that this is not the same as prostitution, because sex is not sold like a commodity and does not take place between prostitute and client, but between boyfriend and girlfriend. The couple is involved in a relationship in which the woman provides warmth, love and sex and in exchange the man provides material gifts (Hunter, 2004: 139-144; 2010: 178, 180-182, 192).

The following case study shows that Cebisile has a main boyfriend whom she expects will eventually marry her, but who so far has failed to provide her with material gifts. Hence whilst waiting for him to pay *lobolo* for her, she has some temporary 'roll-ons' who provide her with gifts. Cebisile is the only female participant who openly informed me about her 'roll-ons'. We were walking through town when she complained about her boyfriend and how he never gave her anything. Although he told her that he loved her all the time, she asked me "what good is "I love you"?". She felt he should be showing his appreciation in gifts instead. Whilst we walked past a shoe shop she told me that she had a roll-on that worked there. To make sure her boyfriend did not find out, she had two phones. The one was for her boyfriend to call her on and the other one was for the 'roll-ons'. Whenever her boyfriend came over to visit her, she turned the other phone off and hid it. The man working in the shoe shop was not Cebisile's only roll-on, she also pointed out a taxi driver, and a soccer player. Cebisile

claimed that she needed these 'roll-ons' because her boyfriend never gave her anything, whilst these 'roll-ons' gave her drinks, snacks, lunch, money for transport, a ride home in their car, etc. During the *ukushela* process men were especially generous as they were trying to convince the women that they were able to provide. I asked Cebisile what she had to do in return for the gifts. She explained to me that she was smart; she would tell them that she was too busy when they asked her to come and visit them at their homes. She would only briefly meet with them in town. She explained that she did not want to have sex with her 'roll-ons', because there was "too much virus out there". She did not want to risk it. When the 'roll-ons' started to demand a 'return on their investments', she broke off the contact. Van Reeuwijk calls this behaviour 'skinning'; when a woman tries to gain as much as possible from a boyfriend without having sex with him (Reeuwijk, 2009: 104).

The third reason why women were involved with multiple men was less calculated and more emotional. I argue that some women participated in the game of *ukushela* because it made them feel good about themselves by boosting their self-confidence. When involved in *ukushela*, these women would be contacted any time of the day to be showered with compliments, which made them feel desired. I noticed with Cebisile, that in the week following her discovery that her boyfriend had cheated on her, she was more open to the *ukushela* of other men. It was as if she needed it to rebuild her self-esteem. Even though she did not take these proposals any further, it did make her feel appreciated. "The most genuine expression of a man's love for a woman is his payment of *lobolo*" (Hunter, 2010: 194). However, in a time when marriage is rare, these women are replacing this ultimate compliment with many small compliments. This demonstrates how they adapt their practices in response to the new reality. They try to make the best out of a bad situation. Hence by having multiple partners, a woman increases her emotional, economic and symbolic capital. However, it also placed her at an increased risk of HIV infection, indicating how poverty increases the risk of HIV transmission. It is important that her involvement with multiple partners remains secret. Therefore in each relationship she has to make her partner think that he is the only one, which makes it hard to insist on the use of condoms. The same goes for men involved with multiple women. Despite the increased risk, their adaptation demonstrates agency, especially in Cebisile's case who avoids having sex with her 'roll-ons'.

6.5.5 Consequences when a man is caught cheating

Just like the women, men who had multiple partners also distinguished between their main girlfriend and their 'hidden' girlfriend(s) (Selikow et al., 2002: 25). Men often put in an effort

to ensure that their main girlfriend did not find out about their hidden girlfriend(s). Their efforts are mentioned in the following two case studies. However, these stories have only come to my attention because the female participants complained to me about their cheating boyfriends. This clearly means that the men's efforts to hide their other girlfriends were not always succesful.

Nomvula, a 23 year old woman, had just had her first baby. She and Mandla were not married, but had started the process. In the seven years that they had been in a relationship, Mandla had not always been faithful to her. One of these cases was out in the open, because he actually had a child with this hidden girlfriend. He took responsibility for the child, but discontinued the relationship with the child's mother. This happened early in his relationship with Nomvula, who decided not to leave him over it. A few years later they started the process towards marriage. Whilst visiting Nomvula's house in 2011, she told me that she thought Mandla was cheating on her again. One of the reasons that made her think so was because sometimes when his phone rang, she could see him press the red button before he put the phone against his ear to say hello. He acted surprised when there was nobody on the other side of the line and told her that his phone must be broken. She told me that every time she caught him cheating on her (which implies this has happened on more than one occasion), he would stop, but then after a while he would start doing it again.

Cebisile, a 24 year old woman, was also in the process of getting married. Her boyfriend had completed the *ukucela* and was saving up for *lobolo*. He worked in Durban, where he stayed in a male hostel. He came back to Pietermaritzburg to visit Cebisile once a month. When I caught up with Cebisile she seemed distressed. She told me that her friends had seen her boyfriend with another woman. I asked Cebisile if she meant in Durban. Cebisile answered that he was not cheating on her in Durban, or at least not as far as she knew. Instead her friends had seen him with another woman in the location where Cebisile lived, and to make it worse, her friends had told her that the woman was pregnant. Cebisile wanted to know if her boyfriend was the father of this child, so she decided to confront him with what she had heard. He denied the whole matter and suggested that the woman was only an ex-girlfriend. No sooner had he said it, when his phone rang. Cebisile told him to pick up his phone, but he did not want to. Soon after the ringing stopped, a text message came in from the woman they were talking about, saying "I love you".

So even though men tried hard to keep their extra relationships hidden, they were not always successful. So how did these women respond when they caught their fiancés cheating

on them? Immediately after Nomvula found out about the cheating she was all worked up. She told me that she and Mandla had been fighting for a few days and that she had threatened to take her belongings out of his room. However, when I met her a few days later she had calmed down again and told me: “It is okay. I know he loves me. He is so happy with his son, and the fact that his son looks like him”. She even justified his behaviour. “Maybe it is because I have the baby now. The past three months I have not been able to visit him at night, because I had to look after the baby”. Cebisile’s response was similar. When she read the message, which said: “I love you”, she became very angry. Her boyfriend tried to calm her down by telling her that it meant nothing, that it would not happen again, and that he loved only her. She did not want to hear him and decided to put a halt on their wedding plans. However, a week later her anger had eased. Although she had always thought that she would immediately leave her boyfriend if he cheated on her, she told me that it was not that easy to leave someone you love. Even though he had made her look stupid and she wondered if she could ever trust him again, she decided to stay with him and the wedding plans were on again. So initially Nomvula and Cebisile reacted angrily or at least made their disapproval known, but when their partners showed regret, offered apologies, and promised that it would not happen again, they eventually forgave them and continued their relationships. Harrison also found that infidelity in many long-term relationships resulted in a hiatus rather than a permanent split (Harrison et al., 2008: 303). Nomvula and Cebisile’s behaviour is in line with what Dingane said would happen when a husband cheats on his wife:

Eva:	What happens if a man cheats on his wife?
Dingane:	Very little
Eva:	Will she not divorce him?
Dingane:	If she wants to divorce him because he cheated on her, it will seem to other people that she was not a good wife. Traditionally women would just keep quiet. They would just accept that their husband was sleeping with someone else.
Eva:	Would she show her disapproval in any way?
Dingane:	She might not do your washing, or cook your favourite meals. You would have to dish up your own plate, and she will not have sex with you. This might last for two weeks. After that things will go back to normal.

According to Dingane, a woman’s disapproval is invisible to the outside world, but will definitely be noticed by her husband. In times when a woman can count herself lucky that she is married, or in the process of getting married, she is likely to think twice before ending her

relationship. Despite not being impressed with his cheating, the capital she receives as a married woman (symbolic, social and economic) is not something to give up easily. This could be one of the reasons why many women quietly accept being in an unfaithful relationship. Selikow suggests that often when the main girlfriend is aware that her boyfriend is cheating, nothing happens, because she does not have the power to insist on a monogamous relationships (Selikow et al., 2002: 25). Talking to Sindisiwe I was given information that resonates with Selikow's argument. Sindisiwe's sister had been married for five years, but had been unable to become pregnant. Her husband cheated on her and caused this other woman to fall pregnant. Although Sindisiwe's sister made it very clear to her husband that she did not want anything to do with this child, she did not decide to leave her husband. Sindisiwe told me that it is not easy for a wife to leave her husband. It was better for her sister to just accept the situation. Sindisiwe explained: "this 50/50 [gender equality] of today is not in line with our culture. Traditionally in our culture it is more like 90/10. So these days it might end up being 60/40. Sometimes you can say something, sometimes you cannot". Hence the real question is what the consequences would be if a woman publicly criticised her partner. The level of criticism is likely to be determined by the level of her dependency on the relationship.

The more capital an individual has, the easier it becomes for the individual to "control one's own fate" (Ritzer & Goodman, 2004b: 523). Korps suggests that this growth in capital also directly links to the individual's capacity to take on health enhancing behaviour (2010: 805), this is also what I have observed among the individuals that participated in this study. From the many accounts I was given about cheating boyfriends, fiancées, and husbands, the following story stood out because eventually Nomsa decided not to keep quiet as was expected of her. When I met Nomsa for the first time in 2007 she was a married housewife with three children. She told me that her husband had impregnated her sister. In the past, when he had cheated on her she had quietly accepted this. However, now that he cheated on her with her own sister she wanted to end her marriage, but she could not do so because she was unable to provide for their three sons by herself and she feared the stigma of being a divorced woman. In short, she could not afford to criticise him.

When I met Nomsa again in 2010 the first thing she told me was that she had left her husband. As previously mentioned in chapter two, Bourdieu speaks of four types of capital: economic, cultural, social and symbolic capital (Ritzer & Goodman, 2004b: 523). I would like to use his economic terminology to explain that Nomsa's ability to leave her husband was

a result of the different forms of capital that she accumulated whilst working at ‘Women and Children First’.

Although Robyn (the director of ‘Women and Children First’) considered what she paid her staff members to be a low wage, the money they earned made a big difference to them and their families. They had started at the NGO as volunteers. This meant that in exchange for working five and a half days a week they only had their travel and phone expenses reimbursed. Over time, as the NGO was able to secure funding, the NGO was able to pay wages. Besides their wages the staff would also often receive food, clothing, and toy donations to take home. As the NGO was getting more financial assistance, the community workers also had breakfast and lunch at the NGO, which helped their wages to stretch further. Their increasing economic capital resulted, to some extent, in financial independence, enabling Nomsa to raise her sons by herself.

Second, Robyn provided her staff members with cultural capital including educational qualifications. Robyn felt strongly about the importance of getting her staff members trained. Therefore she sent the community workers to attend a registered HIV pre and post-test counselling course. Some did a first aid course, others a counselling course, and others again a legal course. Furthermore, she encouraged them to develop their skills by putting them in charge of certain procedures, e.g. staff training, court case attendance, and counselling. The communication, leadership and organisation skills that they gained as a result were useful in their jobs at the NGO, but they also increased their future chances at the labour market, more or less securing some long-term financial security.

Third, Robyn provided her staff members with social capital by increasing their social network. Before they started working at the NGO, most of the women were rural housewives. After getting involved in the professional field, they made more contacts outside their families. They interacted with health care workers, the police, school principals, prosecutors, community leaders, etc. Consequently, they became linked in with their communities, making them feel that the community was looking out for them. On top of the local connections, the women working at ‘Women and Children First’ also befriended wealthy overseas volunteers who spend time at the NGO. These overseas friends proved reliable financial safety nets at times of unexpected medical expenses or funerals. This is an example of how social capital can transfer into economic capital.

Finally the staff members also gained symbolic capital from working at Robyn’s NGO. Community members turned to them for advice on matters of HIV and AIDS, sexual abuse,

family violence, suicide, loss of property, etc. They became well-respected people in their community whose opinions were highly valued. It is likely that this has made Nomsa feel confident that she would not be rejected by her community when she would become a divorced woman. That despite the divorce, she would still have enough merits left.

This meant that even without the capital of a married woman, she had enough economic, cultural, social, and symbolic capital at her disposal to be able to care for her children and not become a social outcast. Nomsa was no longer dependent on her husband. The capital that she accumulated allowed her to become less dependent on what Hunter calls 'provider love' and brought her closer to what Giddens describes as 'confluent love' (Giddens, 1992). As her capital grew, so did her ability to control the terms under which she was involved with a sexual partner. This can be directly linked to her level of risk of HIV infection, as she gained the ability to end risky relationships and demand her 'term and conditions' prior to getting involved. Nomsa's actions validate Susser's argument that the best way to prevent HIV transmission was to provide jobs for women. Susser explained that when women had their own income, they gained the necessary power to avoid risky situations (Susser & Stein, 2004: 137) and this seems to be what happened to Nomsa. It was her accumulated capital that enabled her to make this unconventional decision. As such Nomsa's example demonstrates individual agency.

Earlier I mentioned how having children prior to marriage could be condoned if it was done in a respectful manner. At least a start should have been made to the process of marriage, the father was expected to provide for the child, and the couple were only to secretly meet up. I referred to this as a discreet indiscretion. The same can be said about cheating boyfriends. Their behaviour can be condoned if they cheat respectfully. This is in line with Archambault's argument where she found that in Mozambique a good boyfriend is not necessarily someone who does not cheat, but someone who does it discreetly to avoid his girlfriend being confronted with it. Whereas concealment signifies care, a lack of discretion shows a lack of respect (Archambault, 2009). This seems to ring true for Cebisile who could accept her boyfriend cheating on her in Durban, but who was 'beside herself' when she found out that he had cheated on her with a woman from her area. In the latter case he, in Cebisile's words: "made a fool out of me". Cebisile was told about her boyfriend's cheating by her friends, which was an embarrassing experience. Her biggest concern did not necessarily seem to be the fact that he was cheating on her, but that he had not ensured that it remained invisible to her and her social network. This resembles the idea of *hlonipha* in which

avoidance is used to express care and respect. Similar to Cebisile's boyfriend, Nomsa's husband crossed the line when he took the cheating home by cheating on Nomsa with her sister. With his actions he deeply disrespected his wife, who then decided that he no longer deserved her respect.

6.5.6 Consequences when a woman is caught cheating

Nomsa's decision to divorce her husband was an exception. Most men experienced few consequences when caught cheating, especially when it was done discreetly. So what about the consequences for women when they were caught cheating? When a man boasts about being involved with multiple women, it is likely to increase his symbolic capital. However, when a woman is said to have multiple partners, even when these are only rumours, this can have serious consequences for her reputation and therefore her symbolic capital. The name *isoka*, which is used for a man who has multiple sexual partners, is considered desirable. On the contrary the name *isifebe* (prostitute), which is used for a woman who either has or is believed to have multiple partners, is feared (Hunter, 2005: 390). Nandi repeated to me what she was taught by her teacher.

> When you say *isifebe* (prostitute) your face looks angry. It is a bad word. However, when you say *isoka lamanyala* (man with many sweethearts) your face smiles. This means it is not a bad word.
> (Nandi, a 25 year old female)

Isifebe is a word I have been told by the participants not to use lightly. The dictionary translates it into prostitute, but in practice the word comes closer to our use of the word 'slut'. It is considered extremely disrespectful for a woman to have multiple partners. What I found amongst my participants in KwaZulu-Natal is comparable to what Archambault describes in Mozambique; although men having multiple partners is contested, it is also expected. Yet women having multiple partners is considered unacceptable (Archambault, 2009). I asked Dingane what would happen if he caught his wife cheating:

> Never! If she would do that [cheat] I would divorce her immediately and I will make sure to give her a bad name in the community.
> (Dingane, a 28 year old male)

One of the most common reactions when a woman is caught cheating is that her partner will end the relationship. This is exactly what happened in the story Sibongile told me about her

unmarried cousin. Muhle's wedding was called off because it was believed she had cheated on her fiancée. Muhle and her fiancée were in the process of getting married; *lobolo* had already been paid and the only step left to becoming husband and wife was the actual wedding ceremony. However, this was rudely interrupted by Muhle's sister who made up a story that Muhle had slept with another man. Based on these rumours, Muhle's fiancée called off the wedding. If he could prove that Muhle had been sleeping with another man, her family had to pay back the *lobolo* to his family. However, there was no proof because it was all made up by Muhle's sister. By the time Muhle's fiancée realized it was a lie, he had embarrassed Muhle too much for them to still get married. Instead of the in-house protest that women showed their men when they caught them cheating, men were more likely to make the cheating of their partners a public affair. A cheating woman would experience strong family and community disapproval and as a result she would be deemed undesirable for marriage (Hunter 2005: 394). Hence, in contrast to men, when women were caught cheating it was likely to have long-lasting consequences.

In some cases a husband decided not to end the relationship, but to hold a cleansing ceremony instead. One of Sibongile's family members had requested a cleansing ceremony because he believed his wife had cheated on him. The family had called Sibongile over to calm things down. The husband was very angry, even though the wife denied that anything had happened. In this case there was no talk of divorce. Instead the husband wanted the wife to go through a certain ritual to cleanse her. The husband believed that after this public cleansing ritual they would be able to continue their marriage as if nothing had happened.

Another relatively common reaction is violence. There are men who threaten their girlfriends with violence if they were to ever catch them cheating. Nomvula's fiancée, whom she has caught cheating on several occasions, had warned her that if she ever cheated on him, he would kill her. Violence is also mentioned by Selikow as a potential response when a woman is caught cheating (Selikow et al., 2002: 27).

Altogether it is clear that when caught cheating the possible consequences for women are far more severe and far-reaching than the consequences for men. These double standards encourage power imbalances (Varga, 2003: 168). Both men and women can accumulate capital by having multiple partners. However the difference is that men have to display their sexual conquests out in the open to receive symbolic capital (Selikow et al., 2002: 25). Women, on the other hand, lose their symbolic capital if it is publicly known that they have multiple partners. They can only accumulate capital if they keep their 'roll-ons' a secret. So

women keep this information hidden and publicly distance themselves from such behaviour (Archambault, 2009; Harrison, 2010; Pattman, 2005; Selikow et al., 2002). This explains why I hardly ever heard women talk about having multiple partners. The first and only time a participant told me about having a 'roll-on' was during one of my last weeks of fieldwork.

6.6 Conclusion

This chapter started with an overview of the different steps that a couple is expected to take in order to get married. A comparison between my observations and the descriptions provided in ethnographies shows that besides similarities there are also several changes indicating that the 'traditions' around marriage change over time, which demonstrates the fluidity of 'tradition'. Furthermore, I have also identified differences in what and how 'traditions' are practiced within my observations. This suggests that 'traditions' not only change over time, but are also practiced differently by different families at any one time. This further demonstrates that 'traditions' are not static but dynamic.

This chapter has mainly referred to relationships as strategic tools to accumulate capital. Over the last two centuries marriage has remained an important and highly sought after life event, even when this goal became harder to achieve due to socio-economic changes. According to Zulu custom a boy becomes a man upon marriage. So when a man is unable to get married, his masculinity is threatened and he struggles to acquire symbolic capital. For women the inaccessibility of marriage makes it harder to acquire both symbolic and economic capital. Ideally 'love' is converted into capital through marriage, but in times when an increasing number of people struggle to get married, both men and women have to improvise. In this chapter it has been established that, among other strategies, both men and women have resorted to multiple partners to convert 'love' into capital. It has also been pointed out how these alternative strategies place individuals at greater risk of HIV transmission.

The importance of discretion has been stressed multiple times throughout this chapter, for example in relation to the secret visits by the couple prior to marriage. Although the family might well be aware of these visits, especially when a pregnancy has made what should have remained invisible clearly visible, still great emphasis is placed on couples keeping their visits out of their parents' sight. It is important for the couple not to disrespect their parents. This ideal clearly influences their behaviour. Although it does not stop them from having sex prior to marriage, it does cause them to do so in a discreet manner. I have referred to these hidden activities as 'discreet indiscretions'. When the participants partake in behaviour that does not conform to the social norm, they make sure to do so discreetly. Publicly they

distance themselves from such behaviour, so that officially they still accommodate social expectations. I believe this behaviour is heavily influenced by the concept of *hlonipha*. Discretion also surrounds the topic of multiple partners. For both men and women it is important that their stable partners, parents, and the larger community do not find out about their secret lovers. If it would come out, it could damage their reputation, which converts into a loss of symbolic capital. Therefore they keep the topic hidden. However, a man can only acquire symbolic capital from having multiple partners if he makes it visible to his peers. Hence, depending on the audience, the same behaviour could either lead to a gain or a loss of symbolic capital. This explains why men boast about having multiple partners whilst they are amongst their peers, but deny such practices in other company. This chapter has pointed out how this secrecy increases the risk of HIV transmission.

Similar to chapter five, this chapter has provided more background information. This time the aim has been to give the reader a better understanding of the interaction and negotiation that takes place between men and women, in gender relations. It has described how women are the ones in control of decision making when they are courted, but how they hand over this control to the men the moment they accept their proposal. In these relationships women are expected to refrain from criticism and to quietly accept situations that might not be in their best interest. Understanding these gender relations is of importance as it plays a significant role in the ability of the community HIV educators to implement HIV prevention practices in their everyday lives.

Female submissiveness is part of the Zulu habitus, but in a similar way to the 'traditions' addressed in the previous chapter, this situation is not fixed either. Examples given in this chapter addressed strategic practices by women like Nolwazi, who found ways to be married without having to keep quiet. She explained that by acting respectfully towards her husband he respected her in return, which allowed her to give her opinion. Furthermore, when Cebisile's described her 'skinning' practices, she also did not come across as a woman submissively accepting her situation. Another example given in this chapter has highlighted that women who have access to capital outside their marriage can afford to be more critical; the capital that Nomsa had acquired through her job as community HIV educator, enabled her to leave her cheating husband. An increase in capital reduces the effects of structural factors and increases individual choice.

Throughout this chapter it has become clear that there is often a difference between ideal behaviour (precept) and real behaviour (practice). However the concept of discreet

indiscretions argues that if the ‘real’ deviates from the ‘ideal’, but does so secretly, then this ‘real’ can still be considered ‘ideal’, or at least the next best thing. Nevertheless, when only looking at formal discourse and practice, a great deal of what is actually happening will be missed. Mars suggests that when concealed practice is left out of the calculation, the results will not reflect the reality (Mars, 1982). I agree with Mars and therefore this chapter has not only presented how things ideally should happen, but also what actually happens. Although this information is harder to access, it’s consequences for the spread of HIV are enormous and therefore efforts should be made to gain access. This chapter provided the necessary background information in a lead up to the next two chapters discussing why certain HIV prevention methods are easier or more suitable for the community HIV educators to implement in their everyday lives than others.

Chapter 7: The social life of condoms

7.1 Introduction

The previous two chapters provided a detailed insight into sexual socialisation, how sexual relationships are established, into gender roles as part of this process, and it brought attention to the practice of multiple concurrent relationships. Although the main focus of this thesis is HIV prevention, it has been important to illustrate this more general socio-cultural context because it is in this particular context that the HIV epidemic in KwaZulu-Natal takes place. It is important to realise that this context varies greatly from the socio-cultural context in the USA, Europe, or New Zealand. By understanding this specific context we can come to understand why certain prevention programmes are more culturally suitable than others.

This chapter links the previous two more general background chapters to HIV prevention. When looking at the practice of multiple concurrent relationships from an HIV prevention point of view it is often described as a 'dangerous' practice because it increases the risk of HIV transmission. A particularly 'risky' aspect of these relationships is that, because of the discretion around the practice, the individuals involved are often unaware that their relationship is not exclusive. To prevent HIV transmission in this situation, international HIV prevention campaigns recommend that every couple should use condoms, be they in casual or long-term relationships. After first illustrating the risk of multiple concurrent relationships, this chapter will turn to the promotion of condoms and how this has been received.

Chapter three already illustrated briefly that during the early years of the epidemic the promotion of condoms was not well-received. However, gradually the reporting on condom use has changed and more recently it has been suggested that condoms have become the new norm (Beksinska, Smit, & Mantell, 2012; Berer, 2006; Maharaj & Cleland, 2006; Joanne E Mantell et al., 2011). This chapter takes a critical look at this condom-positive reporting and demonstrates that the reality is more complex. Initially, when I spoke to the participants, they confirmed the contemporary success of condoms. It was not until later in the fieldwork that the participants shared a more critical perspective on condom use. I became aware of the existence of different discourses that had their place in different fields. This chapter describes these different discourses and different fields and demonstrates how the attitude towards condom use changes in each field. It describes examples of community HIV educators who, despite having good knowledge on HIV prevention and having self-efficacy (the two main requirements of the social cognition models described in chapter three), have been unable or

unwilling to implement condom use consistently in their own lives. This leads to the following questions: What can explain why a trained community HIV educator does not consistently use condoms in his or her personal life? What is it about condoms as an HIV prevention strategy that makes them hard to implement? What do these complications say about the social cognition model, individual choice and structural factors? This chapter aims to answer these questions.

7.2 Multiple concurrent relationships and the risk of HIV infection

The previous chapter has already discussed that it was not uncommon for both men and women to have multiple partners. That chapter merely focuses on the underlying dynamics causing both men and women to have multiple partners. This chapter links the practice of multiple relationships to the risk of HIV transmission. Figure 22 shows how HIV has the potential to spread more quickly in multiple concurrent relationships (in which individuals have overlapping sexual partners) than in serial monogamous relationships (in which there is no overlap between subsequent sexual partners) (Mulwo et al., 2009: 312). The top two images illustrate how in multiple concurrent relationships HIV has the potential to spread from one HIV positive male (filled square) and his HIV positive female partner (filled circle) to many (in this case eight) other people in a three-month period. Whereas if both people practice serial monogamy, they would have only just started to spread HIV to two other people in this same three-month period.

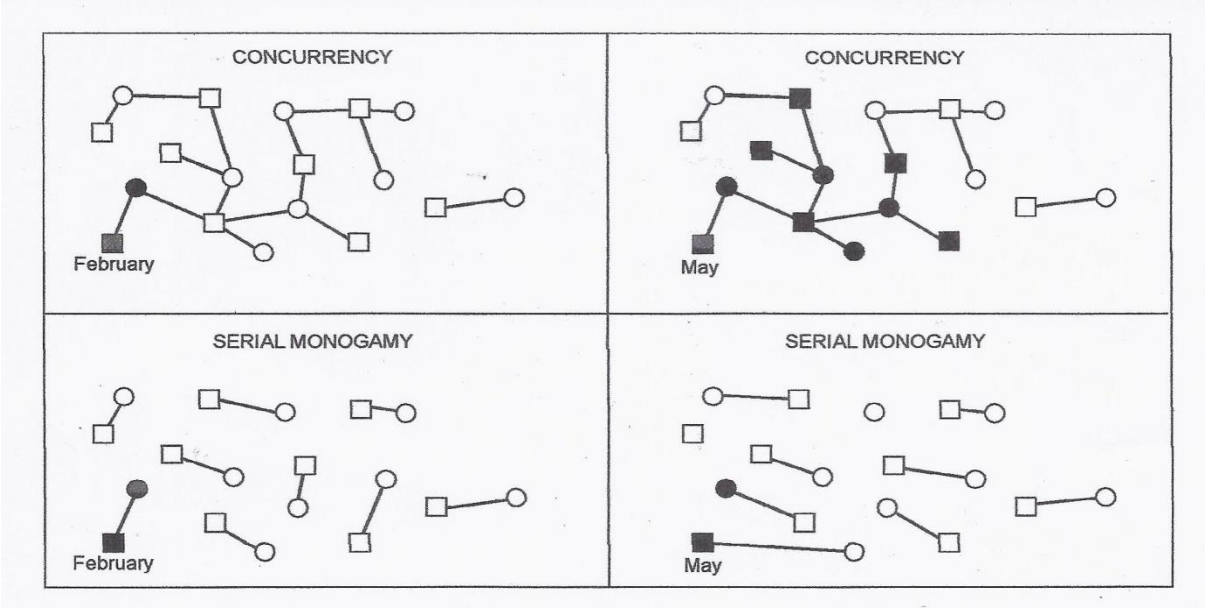

Figure 22: Schematic representation of the potential for HIV transmission within multiple concurrent relationships as compared to serial monogamy
(Mulwo et al., 2009: 313)

When comparing the number of sexual partners over a particular length of time of those involved in concurrent relationships and those involved in serial monogamy, it is likely that both have been involved with the same number of people. However, it is the overlap between sexual partners that increases the rate and efficiency with which HIV spreads (Harrison et al., 2008: 296).

The element of secrecy around the topic of multiple concurrent relationships also came to light in the previous chapter. Considerable energy was put into hiding extra relationships. As a result individuals were generally unaware of the extensive sexual network they were part of, see Figure 23. In South Africa condom promotion has been the key strategy of national HIV prevention campaigns and free condoms have become widely available (Beksinska et al., 2012: 51; Mulwo et al., 2009: 312). As has been previously mentioned, the majority of heterosexual transmissions of HIV in Africa occur in long-term relationships as opposed to casual relationships (Chomba et al., 2008: 108; Desgrées-du-Loû & Orne-Gliemann, 2008: 151; Painter, 2001: 1397, 1398). Cheating by both men and women causes them to infect their long-term partners. For this reason condom use should not only be promoted in casual relationships, as has mainly been the case so far, but also in long-term relationships (Desgrées-du-Loû & Orne-Gliemann, 2008: 151).

The participants I worked with at the 'Bafana AIDS Project' were HIV pre and post-test counsellors and they had been trained to promote condom use among their clients. Ethical limitations kept me from observing their counselling sessions with clients, so in order to experience the HIV pre and post-test counselling I registered myself for an HIV test. Nandi was my pre and post-test counsellor. During the session the importance of condom use in relation to the invisible sexual network was made clear to me. Nandi emphasized I should use a condom with my long-term partner, as she pointed out that I could not know what he was doing whilst I was away in South Africa. To illustrate her point she showed me the following image.

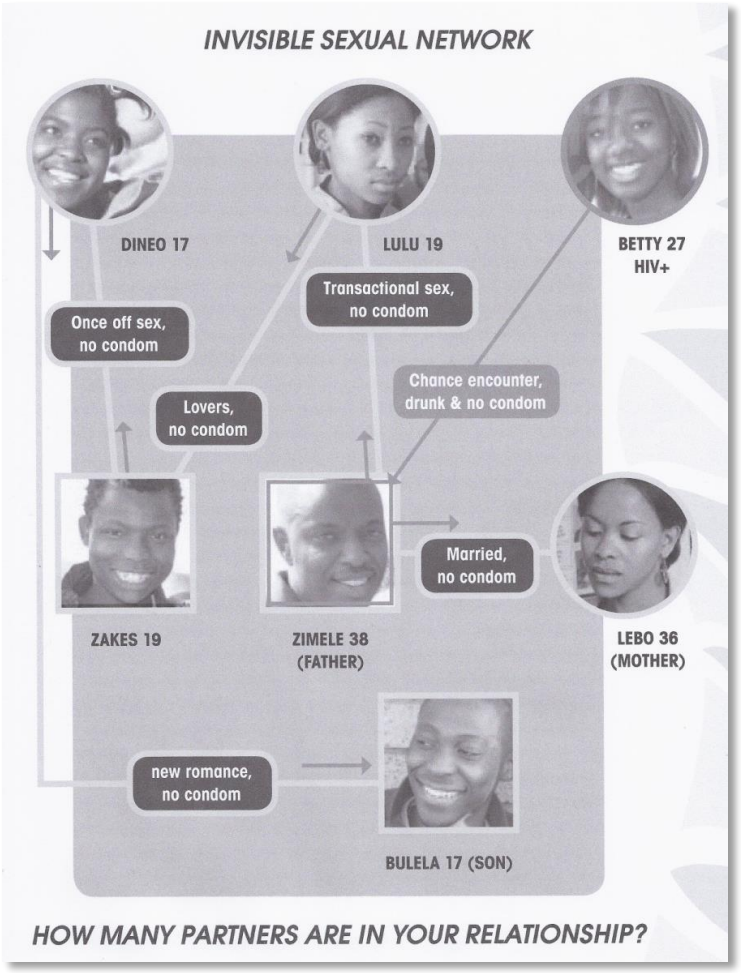

Figure 23: Model portraying the invisible sexual network (Lehloka, 2009: 5)

On another occasion Siphokazi gave me the following explanation of what is happening in this image:

> It shows the chain of HIV. Going from father eventually to his 17 year old son. This is how a monogamous wife can still get in contact with the virus. The husband slips up, gets infected. He infects his own wife. He is a sugar daddy to this girl; in exchange for sex he gives her groceries. He infects her. She infects her boyfriend, etc.
> (Siphokazi, a 22 year old female)

Figure 23 illustrates clearly how a monogamous woman, can still be at risk of HIV infection. Abdool Karim states that in South Africa "simply being married is one of the biggest risk factors for acquiring infection with HIV" (Abdool Karim & Abdool Karim, 2005: 254). However, as the previous chapter has already stated, it is not just men who secretly have multiple sexual partners. As a result of this reality both the national policy and the policy of

the ‘Bafana AIDS Project’ promote the use of condoms in long-term relationships to prevent HIV transmission through the invisible sexual network.

7.3 Condom promotion in South Africa

During the early years of the HIV epidemic in South Africa, condom promotion programmes were struggling to overcome a negative, sceptical, suspicious and resistant attitude towards condom use. The late eighties, the years in which the HIV epidemic arrived in South Africa, were marked by extreme political turmoil and violence. In a bid to overthrow the apartheid regime, anti-apartheid activists encouraged communities to make townships ungovernable and to disregard any policies associated with the white minority government (Tambo, 1985). Understandably, when HIV prevention interventions were initiated by the government during these same years, they were met with suspicion and resistance (Vliet, 2001). It was reasoned that if the government suggested the use of condoms, then condoms could not be trusted. Furthermore, not using condoms was seen as a form of resistance (Stadler, 2003).

This was not the only reason why Africans in South Africa were suspicious of condoms. Whilst the anti- apartheid activists focused on making the townships ungovernable, the government tried to immobilise anti-apartheid activists in a bid to ensure the continuation of the white minority government (Brown, 1987; Kaufman, 2000; Klugman, 1990). Several conspiracy theories circulated which claimed that the white government had poisoned water sources, and food and clothing donations. Wouter Basson, the head of South Africa’s secret chemical and biological warfare project, was the main person linked to these accusations, yet in 2002 he was acquitted on all charges (Niehaus & Jonsson, 2005). The conspiracy theories returned when it became clear that HIV particularly affected Africans. Claims were made that the government was involved in infecting Africans with HIV (McNeill, 2009: 356; Niehaus & Jonsson, 2005). It was argued by some that Basson had manufactured the HIV virus with the help of Americans, or that he had brought the virus over from America which led to the suggestion that AIDS was an abbreviation for American Idea to Destroy Sex. Claims were made that Basson had targeted African soldiers who then spread HIV to the women they had sex with (Niehaus & Jonsson, 2005). In 1999 the Truth and Reconciliation Commission heard a case about two HIV positive ex-members of the ANC who were allegedly employed by the apartheid government in 1990 to spread HIV among sex workers (Barnett & Whiteside, 2006: 166; Vliet, 2001: 156). In these years of turmoil Africans were suspicious of any generosity shown by whites. There is a widely circulated story from 1991 where a batch of oranges that was donated by white farmers, was believed to have been injected with HIV-positive blood.

People were suspicious of their abnormal red colour and refused to eat the oranges. Many crates ended up being dumped into the Durban harbour (Leclerc-Madlala, 1997: 364; Niehaus & Jonsson, 2005: 195-198). Also, the condoms that were distributed by the government for free were believed to have been infected with HIV (McNeill, 2009: 356, 360; Niehaus & Jonsson, 2005: 195-198). As evidence for this claim, people argued that when they put water in a condom and exposed it to sunlight they could see worms appear in the water. Some argued that these condoms had been tested under a microscope which confirmed the presence of HIV (McNeill, 2009: 360; Stadler, 2003: 362-364).

The final explanation for the suspicion surrounding condoms when they were first promoted as part of HIV prevention interventions, originates from the family planning programme of the 1970s in South Africa. The seventies was a time of rising unemployment among Africans, urbanisation, and an increasing black revolt (Kaufman, 2000). Several sources argue that the white minority government started to feel threatened by the growing African population (Brown, 1987; Jochelson, 2001: 173; Kaufman, 2000). Under the title 'quality of life improvement', the government established the South African family planning programme. Large sums of money were invested in the programme. As a result there were twice as many contraceptive clinics as there were health clinics. The contraceptives were made available for free and nurses were authorised to prescribe contraceptives to increase the number of women that could be assisted (Brown, 1987). As part of this family planning programme, women experienced different levels of compulsion to accept contraception. Indirectly they were obliged due to a lack of paid maternity leave, child care programmes, family housing, and job guarantee after pregnancy. More directly they were forced by certain employers who made contraception a prerequisite for employment, or in the case when women were given a contraceptive injection after childbirth without informed consent (Brown, 1987; Kaufman, 2000). Although the state did not openly admit that the family planning services were established to reduce the number of Africans in a bid to remain in political and economic control, factors like suddenly having more contraception clinics than general health clinics, raised serious questions about the government's priorities in relation to the population's overall health needs (Brown, 1987; Kaufman, 2000; Klugman, 1990). As a result many Africans were highly suspicious of the family planning clinic (Jochelson, 2001: 175). They compared the programme to genocide (Brown, 1987: 269; Kaufman, 2000; Klugman, 1990: 268). They believed the apartheid government considered "contraception as a safe way of murdering a nation" (Klugman, 1990: 268). In light of this history it was

unfortunate that the tool promoted to prevent HIV infection also worked as a contraceptive. It was once again believed that the real objective for promoting condoms was controlling African fertility. This resulted in another abbreviation linked to AIDS: Afrikaner Intervention to Deprive us of Sex (H. Phillips, 2004: 34; 2012: 121; Vliet, 2001: 155).

Be they rumours or facts, these discourses were well circulated and shaped people's attitudes towards condoms during the early years of the HIV epidemic and have formed the base for people's contemporary perception of condoms.

Several participants in this study confirmed that initially the promotion of condoms was not well-received in their community. Vusi was one of these participants. He was part of a condom promotion programme in 2004. Part of his job was to distribute condoms in his township. This is how the people in his community responded to him:

> In the beginning people were against us and the condoms. They would say: "Why do you give this to us, you do not even use them yourself", "these condoms are not 100% safe", or "we do not know how to use them". They were worried about the expiry date or potential holes in the condoms. We were teaching these people how to use condoms, but in those days we got discriminated against for doing this.
> (Vusi, a 31 year old male)

Sibongile also described initial difficulties for condom promotion campaigns. She suggested that unclear messaging could explain why initially the promotion of condoms was not well-received. According to Sibongile, when the government first promoted condoms, the information was confusing. This led to people using condoms incorrectly, which in turn resulted in breakages. It also resulted in the spread of myths. Sibongile repeated the theory of condoms causing HIV infection. According to Sibongile, the message and training that came with the promotion of condoms should have been clearer to leave no room for uncertainty and confusion.

Despite these initial problems, several sources suggest that condoms have recently become more acceptable. For instance Maharaj and Cleland (2006: 104,106,110) argue that amongst college students in Durban, condoms are a highly popular method to prevent pregnancy and HIV infection and are considered an accepted part of sexual culture. This is supported by Berer, who states that condoms "are becoming a normal part of sex for a growing number of people" (2006: 11). Mantell also found that young men were accepting the necessity to use condoms to prevent HIV transmission (2011: 866). In 2012 Beksinska refers to national

surveys which show a considerable increase in people reporting that they used a condom the last time they had sex (2012: 51, 52).

These condom-positive findings were also supported by several participants. Vusi, who earlier described the negative response of his community towards condom promotion in 2004, told me that research done in his community in 2006 showed that the attitude towards condoms was changing and that more people considered it acceptable to use condoms. Vusi said he knew that people in his community were using condoms, because he found used condoms in the toilets of the *shebeens* (unlicensed establishment selling alcohol). Sindisiwe, who is a volunteer at several NGOs including the Red Cross, was in charge of distributing condoms to the different *shebeens*, stores and community halls in Faras. She told me that some people asked her for condoms when they saw her on the street. Like Vusi, she also argued that recently more people were using condoms, which she based on the fact that she had to restock more regularly.

So far this chapter has painted a fairly straightforward picture; after some initial problems, the information on condom use has eventually reached the people and has been implemented; or at least so it is concluded, from a rapid increase in condom distribution (Mulwo et al., 2009: 312), and an increase of reported condom use in the Human Science Research Council (HSRC) national survey. This shows an increase in reported condom use during last sexual activity between 2002 and 2008 from 57.1% to 87.4% among men and from 46.1% to 73.1% among women (Beksinska et al., 2012: 53; Joanne E Mantell et al., 2011: 860). Yet I am critical of statistics based on the reported use of condoms, because the high rates of reported condom use in 2008 do not match relevant biomarkers, like the continued high rates of unplanned pregnancies and STDs and HIV infections (Beksinska et al., 2012: 53, 55; Mulwo et al., 2009: 313). This indicates the over-reporting of condom use (Joanne E Mantell et al., 2011: 860).

A. N. Turner et al. (2009) studied the accuracy of self-reported condom use data provided during interviews. Participants of this study were part of a vaginal microbicide trial in which they were specifically told by their counsellor to use the gel in combination with condoms. The same counsellor would later interview them to find out if they were indeed using condoms. After the interview, Turner and her team used a computer questionnaire to ask participants if they ever misinformed the interviewer and why. They found that 79% had misinformed the interviewer at least once. Reasons given ranged from: wanting to be polite, wanting to avoid criticism, wanting to please, seeking praise and approval, fear of being

asked to leave the study when admitting to violating the protocol, or embarrassment when engaging in stigmatised behaviour (A. N. Turner et al., 2009: 759, 761). Considering Turner's findings, it could be that the high rates of self-reported condom use in the national surveys are the result of the participants giving socially desirable responses (Beksinska et al., 2012: 54). In that case the increase in reported condom use would merely signal an increase in people aware of the condom promotion campaigns.

7.4 Case study Vusi

In my qualitative research I also encountered over-reporting. During the majority of the first period of fieldwork I was under the impression that ever since the transformation experienced by working at the NGO, the participants had successfully adapted condoms into their own sexual relationship. I had reason to think so, because this was what they had told me during formal interviews. I only found out later that some of those participants who had convinced me that they used condoms, actually did not do so consistently. To illustrate this I will present Vusi's case study:

Vusi was born in 1980. He was considered the 'naughty one' at the 'Bafana AIDS Project', because he often made sexual jokes. In 1994, when Vusi was 14 years old, he joined his family choir. Two years later he took over the choir and gradually integrated lyrics about HIV and AIDS. The choir performed at all sorts of events. In 2006 Khethiwe, the director of the 'Bafana AIDS Project', saw Vusi perform. She approached him and asked him what he thought his community needed. This conversation led to Vusi establishing a soccer team which did not only play soccer, but also distributed condoms amongst peers. Vusi started working for the 'Bafana AIDS Project' as a volunteer and then in 2007 the mobile HIV counselling and testing facility became a part of the 'Bafana AIDS Project' and Khethiwe asked Vusi to come and work for her as a paid staff member. Vusi became a full time pre and post-test counsellor, whilst also remaining active in his choir.

During a one-on-one interview Vusi and I discussed several matters, including multiple concurrent relationships, gender equality and condom use. The following fragment will show that Vusi feels strongly about condom use:

Eva:	What do you think needs to be done to stop the spread of HIV?
Vusi:	I believe in the ABC [Abstain, Be faithful, Condomise].
Eva:	I saw this commercial the other day of this couple that goes for an HIV test together before they start having sex without a condom. What do you think about couples getting tested together and then having sex without a condom, if they are being faithful?

Vusi: The problem with being faithful is, how do you know? Guys, they like sex. They are charming the girls. They might go to *shebeens* and get drunk. Here they will end up having sex with someone. I think that to condomise is very important, even if we do go for VCT [HIV testing].

Besides this semi-official interview Vusi and I spent more time casually talking. One day, near the end of my first period of fieldwork, Vusi accompanied me to my taxi. We stopped at a shop along the way, where Vusi bought several bags of lollies. I asked him why he had bought so many lollies. He told me that he had bought them for his children. I had never heard him talk about his children before. Surprised, I asked him how many children he had. He told me that he had five children; his firstborn was 12 years old, born in 1999 when Vusi was 19 years old, and the lastborn was one month old. All of his children had different mothers and none of the relationships had lasted very long.

This information surprised me as it showed that after Vusi had started working at the 'Bafana AIDS Project' he had repeatedly been having sex without a condom. This contradicted his earlier emphasis on the importance of condom use. The next morning I was sitting with both Vusi and some of the other male staff members, I asked the others to tell me how many children Vusi had. They confirmed that he had five children. Thabo whispered that Vusi actually had six children, but one of them died as a little baby. There was one question burning on my mind. While I was still contemplating how to ask Vusi without sounding judgemental, one of the other staff members asked this exact question:

Sibusiso: So what happened to the condom?

Vusi: Some of the girls had said that they were on the injection [a popular form of birth control in South Africa]. They had lied to me. Since I started working at the 'Bafana AIDS Project' I knew about the importance of condom use.

Eva: But what about your new born baby then?

Vusi: The condom broke (…) Condoms are just not as nice. That is the idea that we have in our heads. You do not *nyama enyameni* (eat sweets with the wrapper) either.

Thabo: I really hate the smell of condoms.

Sibusiso: Well, you can buy the flavoured ones.

Thabo: Yes, but they are very expensive.

When I asked Vusi how his children were doing, whilst catching up a year and a half later, he told me that he was expecting another baby. This was going to be child number six with again another woman.

The above shows that Vusi wanted me to believe that he had been using condoms ever since he had been properly trained by the 'Bafana AIDS Project'. Vusi's answers say more about the discourse he was following, than about his actual behaviour. If it was not for the information I gained during informal conversations, I would not have had access to this second layer of information that followed in the conversation with Vusi, Thabo and Sibusiso.

Vusi was not the only participant who had spoken to me convincingly about the importance of HIV prevention, but who turned out not to always be using a condom in his personal life. Besides Vusi there was Nondumo, Vusi's younger sister who was involved in both the 'Bafana AIDS Project' and the choir. Despite her detailed knowledge of HIV prevention she had unprotected sex with her boyfriend. This led to a pregnancy, after which her boyfriend left her. Although he was not willing to take the steps towards marriage, he did pay *inhlawulo* (damages) to Vusi's family and he also supported the child financially (which included him putting the child on his medical aid scheme).

Nomsa, who has been mentioned in the previous chapter because she left her husband after he cheated on her with her sister, was also involved in a sexual relationship in which condoms did not seem to be used. Initially, after her divorce, Nomsa made it clear to me that she preferred not having a man in her life. Her main priority was to raise her three biological children and the eight other children she was looking after. Then she met Joe, a wealthy taxi owner who was involved in local politics. Nomsa reluctantly started a relationship with Joe. In my presence, two colleagues talked about Nomsa's situation. One of them had found out that Joe was cheating on Nomsa. She had confronted Nomsa with this information, but Nomsa did not want to talk about it. She had said to Nomsa, "well I hope that you are using condoms". Nomsa had laughed and had mumbled, "you know Zulu men". In saying this she suggested that it was not possible to use a condom, because Zulu men did not like using them.

Sindisiwe, too, admitted to not using condoms with her boyfriend. She and her boyfriend had been together since high school. Official steps towards marriage had not yet been made, because he was not financially able to do so. Sindisiwe told me that the first time she and her boyfriend had sex, they did not use a condom. Talking about it only afterwards, they decided to go for an HIV test. Recently her boyfriend started working in Cape Town. This meant that they did not see each other often. She told me that before he comes to visit she goes to the clinic for the injection (to prevent pregnancy). This suggests that they were still not using condoms. This is further confirmed when Sindisiwe and her friends spoke to me about having sex when a woman is having her period. They told me that their boyfriends did not mind

having sex with them while they were menstruating. I asked them if their boyfriends insisted on using a condom on these occasions. Sindisiwe replied: “to be honest, no, they will not use a condom”.

I have not told the above stories to judge the behaviour of these participants. Instead I have provided these examples of individuals who do not use condoms consistently because I am interested in what it means when a trained community HIV educator does not consistently use condoms in his or her personal life. What is it about condoms that keep an community HIV educator from using them? Why is it so important to Vusi to make me believe he is using condoms? How does this reflect on the social cognition models? What does this say about the community HIV educator’s intentions to prevent HIV transmission? In the remainder of this chapter I will consider these questions.

7.5 Barriers to implementing condom use

Despite their extensive training in HIV prevention with an emphasis on condom use, several of the participants reluctantly admitted that they did not always use condoms. There are several reasons, either given to me by the participants or found in the literature, that keep people from using condoms or that makes it hard to request the use of a condom.

Some people simply do not use condoms because they do not know how to use them (Maharaj, 2001: 253):

> When we organised a workshop on how to use a condom it turned out that people did not know how to use a condom.
> (Cebisile, a 24 year old female)

It also happens that in the heat of the moment, people find it hard to stop when they realise there is no condom available. They often end up having sex without a condom instead (Joanne E Mantell et al., 2011: 859). Otherwise people simply forget about condoms, especially if they are under the influence of alcohol (Abdool Karim & Abdool Karim, 2005: 176):

> One of our staff members, who was a facilitator: teaching boys [about condom use], ended up making a girl pregnant. How is this for leading by example? The question is why did he not use a condom? In the end he told me that he was drunk.
> (Ulwazi, a 39 year old male)

Moreover, men complain that condoms are uncomfortable (Beksinska et al., 2012: 54; S. Levine & Ross, 2002: 93; Maharaj, 2001: 252). Cebisile told me that some men complain that condoms are too tight, a complaint that Bermudes Ribiero Da Cruz also found in her research (2004: 140). Others complain that condoms reduce sensation (S. Levine & Ross, 2002: 93) and therefore make sex less pleasurable (Abdool Karim & Abdool Karim, 2005: 175). Or Thabo, for instance, complained about the smell of condoms. With some of these reasons it could be questioned if individuals speak from personal experience, or if they are merely repeating the normative discourse. According to Berer it is the "entrenched belief that they [condoms] have to reduce sexual pleasure that affects people more than anything" (Berer, 2006: 11). This was affirmed by the participants:

> Some people say they do not enjoy the sex [when using a condom]. They cannot taste, the taste is different. But this is just because they are telling their minds this. It is actually not the case, but they have got that into their minds now.
> (Cebisile, a 24 year old female)

> Condoms are just not as nice. That is the idea that we have in our heads (...). It is just in your mind; if you know what you want in life, you will use condoms.
> (Vusi, a 31 year old male)

Furthermore, both men and women have described condoms as an intrusion (Maharaj, 2001: 252), that spoils the spontaneity (Maharaj & Cleland, 2006: 107) and kills 'the moment' (S. Levine & Ross, 2002: 93). It obstructs flesh to flesh contact and therefore it is experienced by some as emotionally detached, clinical, sterile, impersonal, and lacking passion (Beinart, 2001: 334; Bermudes Ribiero Da Cruz, 2004: 140; S. Levine & Ross, 2002: 93; Maharaj, 2001: 252; H. Phillips, 2012: 120).

Condoms have also been linked to a lack of trust (Abdool Karim & Abdool Karim, 2005: 175; Sobo, 1995; Varga, 1997: 48, 57). Condoms have generally been linked to casual relationships and cheating. So when a person suggests the use of a condom, it can be interpreted as if this person considers the sexual contact as a casual relationship. Furthermore, when a person suggests the use of a condom in an ongoing relationship this can either be interpreted as a confession to having cheated or an accusation that their partner is cheating. Aside from HIV prevention, couples want to communicate to each other that there is trust. Hence they weigh the risk of HIV infection against the risk of the relationship coming under stress (Mindry et al., 2011: 598, 599; Varga, 1997: 55). In certain relationships, such as those

described by Sobo (1995), the psycho-social benefits of unsafe sex seemed to outweigh the risks of HIV infection. In this case the women choose to have unsafe sex as part of an optimistic bias. By having sex without a condom, they assured themselves that their relationships were committed, close and intact, for only women with faithful partners have the freedom to have condom-less sex (Sobo, 1995: 106, 107).

Another reason why people choose not to use a condom is because they consider themselves not at risk of HIV infection. However, this is often based on an illusion of safety. People may have learned about stereotypical HIV risk groups, such as prostitutes, homosexuals, intravenous drug users, haemophiliacs, uneducated people, etc. When they consider themselves not part of these risk groups they have a 'sense of immunity' to HIV and do not see the need to use a condom (Abdool Karim & Abdool Karim, 2005: 175; Barnett & Whiteside, 2006: 346; S. Levine & Ross, 2002; Manuel, 2005: 294; Varga, 1997).

The fact that condoms do not only prevent HIV infection but also work as a contraceptive, makes condom use unpopular amongst those who wish to have a baby (Varga, 1997: 47).

The final barrier that keeps people from protecting themselves or others against HIV infection is gender inequality.[22] Despite many changes over time, Zulu attitudes, beliefs and values are still to a smaller or larger extent influenced by patrilineal descent, polygyny, bride-wealth exchange and a patriarchally derived social order. This influences the expectations of gender roles and sexuality (Leclerc-Madlala, 2009b: 15). Ideal feminine behaviour is described as quiet, demure, and soft spoken. It is considered a compliment when a wife is described as someone who can hardly speak. Furthermore, a wife should be respectful and obedient towards her husband. She should not back chat or question his decisions (Leclerc-Madlala, 2009a: 560). Hence Zulu gender norms prescribe women to place themselves in a position of submissiveness in regard to male authority (Abdool Karim & Abdool Karim, 2005: 253; Leclerc-Madlala, 2001a: 42; Mindry et al., 2011: 590; Varga, 2003: 163). These culturally defined gender roles place men in charge of sexual decision making and thereby obstruct the involvement of their female partners in sexual negotiations, including condom use negotiations.[23] Varga (1997) studied a group of young Zulu-speaking women visiting an

[22] (Abdool Karim & Abdool Karim, 2005; Bonnin, 2000; Gollub, 2006; Gordon, 1995; Maharaj, 2001; Mfecane et al., 2005; Sathiparsad, 2007: 173; Susser & Stein, 2004; Tallis, 2000: 59; Varga & Makubalo, 1996)

[23] (Leclerc-Madlala, 2009b; Maharaj, 2001: 252-257; J. E. Mantell et al., 2013: 117; Mulwo et al., 2009: 314; Ndinda et al., 2011: 3, 4; Scott, Weiss, & Viljoen, 2005: 311; Shefer et al., 2005: 78; Varga, 1997: 47, 57; 2003: 160)

antenatal clinic in a township near Durban in 1997. She established that her participants had a high level of knowledge regarding HIV prevention. Nevertheless, more than half of her participants did not discuss condom use with their partners, because they feared upsetting their partner (Varga, 1997: 53, 57). More recently, Mantell recorded that 48% of her female participants did not feel comfortable asking their partner to use a condom (J. E. Mantell et al., 2013: 117). These are just two examples of many sources that have produced similar findings in KwaZulu-Natal (Abdool Karim & Abdool Karim, 2005; Naidoo, Williams, & Knight, 1991; Preston-Whyte, Abdool Karim, & Zondi, 1991; Sathiparsad, 2007: 173).

7.6 Discourse analysis

It is interesting to note that in Vusi's case study he is able to switch between discourses. I heard Vusi emphasise HIV prevention as his main priority, a discourse in which he describes condom use and remaining faithful to his girlfriend as the only right thing to do. In another context I witnessed him boast about having multiple partners and his dislike of condoms. Yet in another context I observed him turn to complete silence and avoidance around these topics. Vusi's example portrayed one person and one discursive theme (HIV prevention through condom use), but three different discourses. His case was not unique, I observed the same thing among other participants.

The following describes three fields (the professional field, the public field, and the domestic field) in which the three discourses portrayed in Vusi's case study were set. It also adds a fourth discourse observed exclusively among the female participants interacting in the public field with their peers. What do the participants achieve by using these different discourses? What is the subject position of the participants when they speak in these different discourses? How do the different discourses influence the actual practice of condom use? Finally, how do the different discourses influence subjectivity, the way condoms are perceived and experienced? These questions are part of the discourse analysis as designed by Willig (2008), described in detail in chapter four.

Studying these discourses is of interest to this study because the discourses clearly state the expected behaviour of individuals, what they are and are not expected to say and do. The experiences of individuals are:

> largely written for [them] by the multitude of conflicting discourses of which [they] are a part. This is not to say that [they] do not strategically draw upon these discourses. But [their] ability to act strategically is limited by the discourses that accompany [their]

intervention and the complex processes of social construction that precede it (N. Phillips & Hardy, 2002: 2).

It makes the abstract concept of habitus tangible by bringing to attention the external pressures on individual practice.

7.6.1 Professional field, as community HIV educators

I refer to the NGO setting as the professional field because this is where the participants acted from a paid position as community HIV educators. This professional field was dominated by a condom-positive discourse. I argue that in this context the theme of condom use was discussed in a way consistent with the social cognition model. As described in chapter three, according to social cognition models the intention to act on a health risk is dependent on the awareness of the susceptibility and severity of the health risk and the individual's deliberate consideration of the cost versus the benefits of a particular intervention, whilst also considering what other people expect them to do. Eventually, self-efficacy (perceived behavioural control) determines whether this intention is converted into actual practice or not.

Similarly to the social cognition model, the participants' statements suggest that when an individual is aware or 'enlightened' on the risk of HIV transmission, when the individual knows that condoms can prevent this transmission, and finally when the individual realises that the responsibility of remaining healthy is in his or her hands, then the individual will choose to use a condom. Prior to starting their job at the NGO each community HIV educator received training. When I spoke to Vukani he had recently finished a pre and post-test counselling course. In the following fragment Vukani stresses how first and foremost education is the key to behaviour change. Near the end he also stresses that is important for individuals to become aware that they themselves have to take control over their own lives:

Eva: How can you bring about behaviour change?

Vukani: By educating people. By training them. Since I have done this course [pre and post-test counselling course] I am constantly thinking HIV. If people have more information they will adjust their lifestyle. They will watch their drinking, make sure not to end up having unprotected sex. They will be more alert. They will be tested. They would not be scared of testing. They know it is best to know. The earlier the better. They would also treat people who are HIV positive better. This course helps you to grow. I have been so impatient before.

Eva: So do you think that if people have the knowledge they will use condoms?

Vukani: Yes, it is just a lack of information. If a man has the info then he will change. It will even change the cultural man. (…) With the course [HIV pre and post-test counselling course] also comes the importance of knowing your rights. It is about YOUR life. It is your life, you cannot expose yourself. Even if married you cannot put yourself at risk just because you are married.

The participants describe how they used to behave in ways that were self-destructive, but since working at the NGO they have come to realise that there is another way in which to live, which places them in charge of their own health and happiness. They describe how joining the NGO has transformed them:

In the past I have had many girlfriends. But now I have changed.
(Thabo, a 28 year old male)

Phazamisa and Sduduzo, talked to me about the scene they used to be part of prior to becoming HIV pre and post-test counsellors. They would go out drinking and their excessive alcohol consumption would often lead to fights:

Sduduzo: Look here (he is pointing at a scar in Phazamisa's neck)

Phazamisa: This happened when I was drinking. The violence was going to kill me one day. I had to stop drinking.

Sduduzo: To be a good counsellor you have to work through your own bad behaviour. Start living positively. You have to practice what you preach. So you have to use a condom.

Phazamisa: Unless you would like to have a child. In that case you have to both be tested. And importantly: close your window period[24], only then you can go ahead.

Since working at the NGO they learned how dangerous their previous behaviour had been and they learned that they could control their own fate:

Since I started working at the 'Bafana AIDS Project' I knew about the importance of condom use. If you know what you want in life, you will use condoms.
(Vusi, a 31 year old male)

[24] It can take up to three months following infection before the virus can reliably be detected. These three months are referred to as the window period. Although the virus is undetectable at this stage, the risk of HIV transmission is exceptional high during this initial period of infection.

These men described working at the NGO as a turning point in their lives. After being 'enlightened' they started to take responsibility for their own lives in the form of a more caring masculinity, one in which they did not need to participate in violence, or in multiple relationships, or in having children to prove their manliness. Instead, they promoted a responsible masculinity in which HIV prevention had a respectable place. This did not take away the competition between men regarding their popularity among women, they merely incorporated HIV prevention into their approach. For instance, when Sibusiso was playfully flirting with me, Thabo responded: "You should not choose him. It is not safe, because he has not been tested. But you will be safe with me, I have been tested".

The discourse presented to me by the participants is in line with the protocol of the HIV prevention organisations. It is a strategic move for the participants to use this discourse in this field, as it demonstrates their credibility as HIV educators. They will seem fit for the job and therefore it secures their income. All the participants started at the NGO as volunteers. During this trial period their performance was closely monitored. If they performed well, they would be offered a paid position. Hence, they learned to perform according to the protocol.

In chapter five the participants described their initial awkwardness when, in their role as community HIV educators, they talked to older clients about HIV prevention and sexuality. Such an interaction was unthinkable in their families or their communities, yet in this professional setting it was possible. To aid the conversation a professional approach was crucial. In any other setting the subject position of the participant would cause him or her to be submissive towards this older person. However, when interacting in this professional field the community HIV educator holds an authorative position in relation to his or her client, irrespective of age.

Whilst participating in the professional field, the community HIV educators' discourse reflected the protocol of the NGO. They were trained to promote condom use when counselling clients. When they spoke as community HIV educators there was no room for uncertainty. When officially speaking about their private lives, their stories confirmed the condom-positive discourse. When talking to them in this field, the participants made it clear that they perceived having sex without a condom as an unsafe practice and unnecessary risk taking. They suggested that, just as it had happened to them, if others had the proper information and would realise that they were in charge of their own lives, they too would change their risky behaviour.

7.6.2 Public field, as friends

The above has described the condom-positive discourse in line with the social cognition model as the dominant discourse in the professional field. I observed two different discourses when the participants were in the public field among their friends. Among the male participants the theme of condom use was approached from a tough masculinity discourse. In this field the participants boasted about the number of girlfriends and children they had or were able to get, how they were invincible to HIV, and how they did not like to use condoms.

When in the company of his male peers Vusi always had impressive stories. He would often talk about his tricks to make women fall in love with him. For instance, he told them that he would apply some 'Vicks VapoRub' under his eyes to make his eyes water. "Women like sensitive men", he explained. He would brag about the number of women he had slept with and make sexual jokes. It was well known among his peers that he had fathered many children, all with different women. As a result he created an image of a man who was popular with women and who was not afraid to take a risk. When Vusi gave me the following answers, he was among his male peers. About multiple girlfriends he said:

> One girlfriend is not enough, because she might not want to have sex with you or she could be cheating on you. For this reason you should always have more than one girlfriend. I once had a coloured girlfriend, she left me when she found out that she was not my only girlfriend. Coloured women do not like this, but many Zulu women do not mind it when you have more than one girlfriend.
> (Vusi, a 31 year old male)

About condoms he said:

> Condoms are just not as nice. That is the idea that we have in our heads. You do not *nyama enyameni* (eat sweets with the wrapper) either
> (Vusi, a 31 year old male)

Similar to Pattman (2005) and Harrison et al. (2008) I found that Vusi's boasting that took place when he was among male peers to be in stark contrast with the discourse he presented when he was in the professional field. Another example shows how the invincibility to HIV is also part of the boasting. When we drove past a random woman who was walking along the road with a couple of children by her side, the following suggestive conversation took place between Sibusiso and Dingane:

Sibusiso: There is the mother of your children

Dingane: No, this one has too many boyfriends, I am thinking about just taking my children and leaving her.

Sibusiso: How do you know they are yours?

Dingane I will have to do a DNA test.

Sibusiso: But why did you not use a condom?

Dingane: I am immune to the virus.

Dingane felt the pressure of the tough masculinity discourse. He told me that he was almost thirty (he was 27 at that time), yet he had not accomplished anything. He did not have a wife, no children, no house, no car, not even a cell phone. He felt that something had to happen in his life. Although some would consider it an achievement that he had not given in to peer pressure to have children, seeing that he was not in a serious relationship and he was not in the financial position to provide for a child, Dingane's peers were not impressed. Instead among his peers he was known as the one who was shy with the women. Eventually this pressure got to him. Just before he turned thirty he fathered a child. The relationship with the mother of the baby did not last.

By using this discourse in this field, the participants accentuated their manliness. In response they received respect from their peers, or at least they avoided being ridiculed. Men who struggled to get married, in particular, felt the need to express their manliness in this manner. Based on their ability to participate in this tough masculinity discourse, men are judged by their peers as either tough or weak. Those deemed tough find themselves in a superior position over those deemed weak and their opinions will be held in a higher regard.

This is a condom-negative discourse that stimulates risk taking behaviour and contradicts the 'professional' discourse. Condoms are not highly valued because they signal a fear of HIV and they block the free flow of bodily fluids. As such they block masculinity and those who support the use of condoms are perceived as weak. There is one exception to this rule. On some occasions the negative perception of condoms can be disregarded when condoms, as a symbol, are merely used to signal sexual activity. I observed this at a visit to a high school where the 'Bafana AIDS Project' provided HIV counselling and testing for those pupils who wanted to be tested. A group of mainly male pupils had gathered around the reception area where they had spotted the box of free condoms. After one pupil had taken a package of condoms, the other pupils followed with a lot of bravado. I argue that in this case, those who took the condoms suggested to their peers that they needed them because they were sexually

active, which was positively linked to a tough masculinity. This does not have to mean that they were sexually active, or that they were indeed using these condoms. The condoms merely functioned to impress their peers.

Observing some of the female participants with their friends in the public field the theme of condom use was approached from what I will call an accommodating discourse. These female friends advised each other to accommodate their partner's wishes. If a partner did not want to use condoms, they should not insist. They advised each other on how to keep a man happy. An example of this has been discussed in chapter five when Nolwazi and Precious advised me in the middle of a restaurant how a good relationship needs regular 'leg over and chips' and a dry 'guava'. When women can keep their men interested, they will not have to look elsewhere, is what they told me. Compared to their feeling of powerlessness when it comes to implementing condom use, keeping their men happy was something they could do to reduce their risk of HIV infection. Among their friends the women interacted from an equal subject position which allowed them to speak openly about sexual matters. This discourse maintained or even further established the idea that men were not interested in the use of condoms. This discouraged those who may have thought about discussing condom use with their partner. Hence, when both men and women were among their friends in the public field a condom-negative discourse dominated.

7.6.3 Domestic field, as family members

Yet another discourse could be observed in the domestic field when both male and female participants were in the presence of their parents or other family members. As chapter five has already illustrated, in this field there was no boasting about sexuality, nor were there open discussions about HIV prevention. Officially there was no talk about condom use. The theme was approached from a discourse of silence and avoidance or *hlonipha*. Most of the participants mentioned that their parents had not spoken to them about sexuality and HIV prevention. Despite the taboo, more recently some parents became more involved in sexual education. This has taught the participants that although officially talking about sexuality is inappropriate, some situations require small adjustments to the rules. However, if one has to make adjustments, discretion is the key. In other words *hlonipha* is a respectful way of dealing with change. Cebisile's mother talks to Cebisile about HIV prevention, but she does so only when she is out of earshot from her husband. The male participants invited me to come home with them, but when we were at their home they ignored me and asked their sisters and aunties to look after me instead. Couples start families despite not being married,

but they remain living separately until they are married. All of these out of the ordinary actions can be accepted, because they officially express *hlonipha*. What happens behind the scenes is not judged, as long as it stays out of sight. By practicing *hlonipha*, children received respect and approval from their parents. This allowed the continuation of their economic and social support. This is especially important in a context in which children generally live with their parents until the day they get married. In interaction with their parents, children are expected to take on a submissive position in which they express their respect to their parents. Subsequently, in relation to their children (and the majority of the participants were themselves parents) they are in a superior position. In the relationship of parent and child the participants could not speak about sexuality. Only when they changed their subject position by 'acting as if' they were peers or siblings, could parents talk about sexuality with their children. So officially when it comes to communication within families about condom use, the participants consider talking about HIV prevention as sensitive and out of place, but behind the scenes gradually more families are finding ways to bring the matter to their children's attention.

7.7 Sexual negotiation by couples

The above has described four different discourses in which the use of condoms is either supported, discouraged, or (officially) left unmentioned. What has not been discussed so far, is how these different, and at times conflicting discourses affect the negotiation taking place between sexual partners ultimately leading to the use of condoms, or not. Whereas participant observation has provided me with the insights presented earlier in this chapter, this final interaction has for obvious reasons been off-limits for participant observation. Hence, the following information is based on what participants have shared about this interaction to a third party, either myself or other researchers.

It is clear that the participants provide over sufficient information on HIV prevention, seeing that they have been trained as community HIV educators. On top of their factual knowledge they also speak of their personal transformation which has made them realise that they are responsible for their own health and wellbeing. Yet, despite meeting all the requirements of the social cognition models, Vusi, Nondumo, Nomsa and Sindisiwe have shown not to use condoms consistently.

This indicates that the route from knowledge to practice is not as straight forward as the social cognition model has suggested. This chapter has stressed that individuals switch between different and at times conflicting discourses. They are juggling different expectations

and their behaviour is socially determined. Each discourse is clear about its behavioural expectations and instead of individual choice it is these expectations that heavily impact the practice of individuals.

Chapter five has discussed how talking about sexuality has experienced gradually increasing levels of taboo in Zulu culture. Avoiding the topic of sexuality has become a way of expressing respect which does not aid the open discussion about condom use between a couple (Leclerc-Madlala, 2001a: 41; S. Levine & Ross, 2002: 89; Maharaj, 2001: 254; Joanne E Mantell et al., 2011: 863; Ndinda et al., 2011: 7). Additionally chapter six on gender relations has identified male dominance and female submissiveness when it comes to sexual decision making (Maharaj, 2001: 254; Mulwo et al., 2009: 314). Women often found it difficult to negotiate sexual practices with their partners (Bermudes Ribiero Da Cruz, 2004: 145; Joanne E Mantell et al., 2011: 864). As a result, the topic of condom use is often left unspoken. Instead of an open discussion, it is unspoken assumptions of what the other person might want that determine behaviour (Berer, 2006; Mulwo et al., 2009: 314; Varga, 1997: 57). Bermudes Ribiero Da Cruz (2004: 146) argued that women are hesitant to discuss condom use, because women think that men dislike condoms. According to Eijnden, Buunk, Bakker, and Siero (1996) this also works the other way around. They demonstrated that an individual who is convinced that the majority of people use condoms, is more likely to expect that their future partner will be accepting of condom use and will therefore find it easier to discuss condom use. "The behaviour of similar others has a normative value (...) the perceived social norm of one's sexual partner is a strong predictor of one's own condom use intention" (Eijnden et al., 1996: 467, 468). Hence, HIV prevention practice is not solely determined by individual choice and does not take place in a social vacuum, instead sexual practice is largely influenced by habitus. People tend to act in accordance with common norms and values, because conformity is socially rewarding, whereas non-conformity could lead to social rejection (Eijnden et al., 1996: 468). In this research area condoms are often negatively associated with casual relationships, discomfort, and a lack of trust (Abdool Karim & Abdool Karim, 2005; Beksinska et al., 2012; Bermudes Ribiero Da Cruz, 2004: 140; Maharaj, 2001: 255; Varga, 1997). Due to these associations condoms are considered out of place in long-term relationships (Beksinska et al., 2012: 53, 54; Bermudes Ribiero Da Cruz, 2004: 146; Harrison et al., 2008: 296; Joanne E Mantell et al., 2011: 859, 864). Couples who believe themselves to be in an exclusive relationship would not feel the need for condoms (Bermudes Ribiero Da Cruz, 2004: 139; Manuel, 2005: 293). All of this would have

influenced how Vusi, Nondumo, Nomsa and Sindisiwe perceive condom use and how they expect their partner to respond if they would suggest the use of condoms. I argue that this explains why they, despite being well informed and 'enlightened', end up not using a condom consistently.

The disjuncture between the different discourses in the different fields, in my opinion, does not make their condom-positive discourse hypocritical. The fact that they promote ideals that they themselves might not always be able or willing to keep, does not necessarily mean that they do not believe in the value of these ideals. Although they might be experiencing barriers that keep them from practicing these ideals, they could be hopeful that others, maybe the next generation, do not experience these barriers, or are able to overcome them. If enough people promote condom use, it could become part of the new normative discourse which would make it easier for individuals to implement the practice. By using the condom-positive discourse in the professional field they are possibly putting change in motion.

7.8 Conclusion

In a reality in which an increasing group of men and women resort to multiple concurrent relationships to accumulate symbolic and economic capital and in which women risk a relationship breakup when insisting on the use of condoms, not using a condom might well be a strategic decision. In this case a complex set of social and cultural factors outweighs the potential threat of HIV infection (Varga, 1997: 58).

Through a discourse analysis the abstract concept of habitus has become tangible, because the discourses clearly state the expected behaviour of individuals, what they are disposed to do. The discourse analysis has brought out different structural factors limiting the options available to an individual.

The lack of condom use does not signal an ambivalence regarding HIV prevention. Whilst the condom has proven to be particularly challenging to implement, the participants have turned to alternative strategies to reduce the risk of HIV transmission in their personal lives. These alternative strategies are discussed in the following chapter. Attention to these alternative strategies emphasises the importance of not solely focusing HIV prevention campaigns on condom promotion.

The struggle to implement condom use described in this chapter, may have presented individuals, particularly women, as lacking agency. By doing so I may have unintentionally reinforced the stereotype of a static African female submissiveness. Instead my intention had merely been to bring attention to structural properties that complicate HIV prevention. I

believe that even within these constraints women have agency and are able to introduce change. To support this argument the next chapter will attend to strategies implemented by both male and female participants to reduce the risk of HIV transmission. As such, instead of focusing on the inability to act, the next chapter will focus on what the participants *are* doing to prevent HIV transmission.

Chapter 8: Alternative interventions

8.1 Introduction

This thesis is concerned with the willingness and ability of community HIV educators to introduce HIV prevention in their personal lives. Worldwide the number one intervention associated with HIV prevention is the promotion of condoms. Yet as the previous chapter has demonstrated, the uptake of condoms in KwaZulu-Natal has not been as straight forward as elsewhere in the world. I argue that the moderate interest in the use of condoms should not be interpreted as a lack of interest in preventing HIV infection. To support this argument this chapter analyses three alternative HIV prevention interventions that have been received with more enthusiasm and *are* being implemented by the participants. These interventions are: HIV counselling and testing, medical male circumcision, and virginity testing. These were the only three interventions that were widely discussed among the participants. The literature identifies additional alternative HIV prevention interventions that were not mentioned, like female condoms, ARV treatment as prevention, STD treatment, female microbicide, etc. Some of these interventions never gained great popularity, others were not cost-effective, and some are still being trialled (Beksinska et al., 2012; CDC, 2010; J. Cohen, 2011; J. E. Mantell, Scheepers, & Abdool Karim, 2000; A. N. Turner et al., 2009).

The first alternative intervention to be discussed in this chapter is HIV counselling and testing and more particularly couple testing. HIV counselling and testing is not only used as a diagnostic tool, but also as a prevention tool as it encourages the reduction of HIV risk behaviour. Some of the participants consider regular HIV counselling and testing as an alternative to condom use in long term relationships. The second alternative intervention is medical male circumcision. This can be considered an HIV prevention strategy because it reduces the risk of men getting infected with HIV in a heterosexual relationship by fifty to sixty percent. Furthermore the circumcision protocol includes HIV counselling and testing, which has the aforementioned preventative impact. The third alternative intervention is virginity testing. Girls who join virginity testing groups have their virginity tested regularly. The idea behind this practice is that the testing and the camaraderie that is established in these groups encourages a delay in sexual debut. Members of these groups might aim to remain virgin until they finish high school, university, or until they are married. The detailed description of these three alternative interventions that follows clarifies that HIV counselling and testing, medical male circumcision, and virginity testing go far beyond and involve much

more than a diagnosis, a snip, and a quick peek at a young woman's private parts, instead they are elaborate interventions addressing behaviour change.

This chapter argues that compared to condom use, these three alternative interventions have been better received and have led to a quicker take-up. The previous chapter has identified the following barriers to the implementation of condom use. Condoms were perceived as a foreign and inappropriate intervention, condoms were considered to spoil the sexual experience, and as a result of gender inequality established couples (as opposed to being in the courting phase) struggled to negotiate the use of condoms. Hence in an attempt to explain why these alternative interventions have been more popular, this chapter looks at how these interventions have been launched and in particular the role 'tradition' plays in the promotion of these interventions. It also looks at the timing of the intervention, and to what extent the intervention interferes or even spoils the sexual experience. Furthermore it addresses the negotiation that is required between couples to implement each intervention.

The conceptual framework in chapter two has brought attention to structural factors limiting individual choice. What is generally perceived as appropriate is easier for an individual to implement and this chapter shows how (referring back to chapter five) being considered 'traditional' aids a practice to be considered appropriate. This chapter shows how change is possible in a reality of structural factors that the previous chapter has essentially described as inflexible and static.

8.2 HIV counselling and testing

Sibongile works at 'Women and Children First'. She is in her forties and is not married. Last year (2009) she ended her relationship with Moses who she had been together with for several years. Recently she resumed her relationship with Bonga, a man that she had dated over twenty years ago. When discussing the topic of HIV prevention, Sibongile told me that Moses did not mind using a condom and about her negotiation with Bonga she told me the following:

Sibongile: I asked Bonga "what is your status? If you want to sleep with me, I need to know your status, or we should use a condom. If you do not want this, you must go on to the next [person]. You should be tested. I want to see your status on paper. I do not know you and you do not know me. I do not know anything about your previous partners [emphasising plural] and you do not know about my previous partners [emphasising plural]. I am HIV negative and I do not want that to change. I know what I want in life. I want to stay alive. Be there for my son".

Eva: How is it possible that you are able to say this to Bonga?

Sibongile: Because I have seen too much. I do not want to be the stats of South Africa. I do not want to die of HIV or a car crash. I do not want to die of something that I could prevent. I want to stay out of danger. I am proud of myself. I do get tested. I do this testing to show that this is no problem. (…) And now with Bonga, I told him he must get tested. We were tested together. He is unlucky to have me, because I ask him what about the window period? So every three months we are tested. I know when we started we were both HIV negative so if I test HIV positive later he knows I will ... I have told him I will sue him. I have the proof. He knows. Yes he knows me. I know what I want. I do not do things that I do not want. Bonga asks me "why are you so worried about getting tested over and over again". But it is me he is dealing with. I tell him "because I do not trust you. You are a man". I do not want to appear in the statistics of South Africa, be the one who brings 49 to 50. I do not want to be that person.

It is questionable that Sibongile talked to Bonga in this manner, which is significantly different from the normative discourse expected when a woman interacts with her partner. Instead the way Sibongile refers to independence, clear life goals, health over love, the risk of trust, self-reflection, HIV prevention jargon, and legal support represents the discourse central to the professional field. Hence the exact way in which Sibongile suggested HIV testing to her partner is debateable, but what stands out in this fragment is that Sibongile presents HIV counselling and testing as an alternative to the use of condoms, as a strategy to reduce the risk of HIV transmission. She was not the only participant to do so, and also Mindry et al. (2011: 596) refer to this alternative strategy in their research.

8.2.1 HIV counselling and testing as an HIV prevention strategy

In this case voluntary HIV counselling and testing is not only used as a diagnostic tool, but also a prevention tool. Several authors claim that HIV counselling and testing is effective in reducing HIV risk behaviour.[25] I argue that there are four ways in which HIV counselling and testing works as a prevention tool. First, in the case of a positive result, the diagnosis halts further ignorant transmission of HIV. According to Fröhlich "most people will probably adopt safer sexual behaviour after the diagnosis of HIV infection" (Fröhlich, 2005: 355).

Second, by administering ARVs the risk of heterosexual transmission reduces by 96 percent (J. Cohen, 2011). This means that an HIV positive person on ARV treatment becomes considerably less infectious (Fleshman, 2011). Whereas in the past a clear distinction was

[25] (Abdool Karim & Abdool Karim, 2005: 237; Chomba et al., 2008: 108; Creel & Rimal, 2011: 901; Desgrées-du-Loû & Orne-Gliemann, 2008; Mathews, 2005: 155; Namjilsuren & Barton-Knott, 2011; Painter, 2001: 1397; Weinhardt, Carey, Johnson, & Bickham, 1999).

made between treatment and prevention, as a result of these findings HIV treatment can become prevention (J. Cohen, 2011). That is, if countries have the resources and political will to make ARVs available upon testing HIV positive (Fleshman, 2011). After a problematic start around ARV treatment in South Africa by President Mbeki, President Zuma has shown the political will to deal with HIV/AIDS head on. In April 2010 President Zuma announced a large upscale in ARV treatment. Up until then only a person with a CD4 count under 200 was eligible to ARV treatment provided by the government. As part of the upscale, Zuma announced that all HIV positive children under a year old can start their ARV treatment irrespective of their CD4 levels. Furthermore HIV positive people with TB or pregnant women can start ARV treatment with a CD4 count of 350 or less (Zuma, 2010a). A further upscale has taken place since, and at present everyone who tests HIV positive with a CD4 count of 350 or less is entitled to ARV's and HIV positive pregnant women and children under the age of 5 are entitled to ARV irrespective of their CD4 count (Cullinan, 2013).

The participants at the 'Bafana AIDS Project' are HIV pre and post-test counsellors. In the following fragment Siphokazi explains what he does when a client tests HIV positive:

> You will try and find out if there is anybody in their social network that they feel comfortable disclosing to. It is important for them to have somebody they can talk to, so that they do not die of stress. The 'Bafana AIDS Project' also gives them a referral letter to go to the closest hospital or clinic so that they can go for a CD4 count and counselling. On top of this the counsellor takes their details and contacts them for a follow up, to see if they are doing ok.
> (Siphokazi, a 22 year old female)

Dingane is the person who manages these referrals:

Dingane:	We realize that it is a lot to take in all at once for the client.
Eva:	In your experience of all the referrals how many of them actually go [to the clinic to do a CD4 count]?
Dingane:	Let's say out of 10, 5 will go and the other 5 will not.
Eva:	What are their reasons for not going?
Dingane:	Maybe they are not ready yet. They might still be in shock. Or they are in disbelief; they do not believe they are HIV positive. Maybe they have not had access to the clinic yet; some places only have a mobile clinic once a month. Or they tell me that they have been working. It is my role to show them the bigger picture. If they do not believe the test was true, I will suggest another place for them to get tested again.
Eva:	I would have thought that when people are ready to be tested, they are ready for the next step?

Dingane: No, it could be that they are tested just to prove to themselves that they are not HIV positive. So then when they actually are, they have a hard time accepting it. It could also be that they did not really decide to get tested. Their friends were going, so they did it too. They are not ready for the outcome.

Third, the process of HIV counselling and testing has a preventative impact. The testing forces an individual to consider their personal risk factors which has the potential to lead to the reduction of risk behaviour. Instead of receiving plain information about HIV, during the counselling session a client is assisted in doing a personal risk assessment. A further moment of personal reflection is likely to take place during the fifteen minute wait for the results of the HIV test. Several people told me that they made a promise to themselves during that moment that they would avoid any situation that could have them worry about their status ever again. Altogether this experience makes HIV real at an emotional level. According to Painter and Matthews compared to only receiving basic health information, undergoing HIV testing, including and pre and post-test counselling, has considerable more impact on behaviour change (Mathews, 2005: 155; Painter, 2001: 1397).

For the best results HIV counselling and testing should consist of a client-centred counselling approach, personalised risk assessment, development of a personalised risk reduction plan, and appropriate referrals (Weinhardt et al., 1999: 1403). When I ask the participants what is important in pre and post-test counselling sessions, Themba suggests that the counsellor first has to establish if the client is ready to find out their status. Next, Phazamisa tells me, the counsellor will check how much the client knows about HIV and AIDS so that they can determine what they still need to explain to the client. From here it is important to make the client feel comfortable to answer the personal questions that the counsellor has to ask. After this the client will be guided to reflect on their individual risk of HIV infection. Then the counsellor and the client set up a risk-reduction plan; specifying what the client can do to stay negative, or who they can turn to when they test HIV positive:

You cannot tell them what they must do, you can only encourage them. Give them information about what they should do to stay HIV negative; abstain, use condoms, or be faithful. For those clients who maybe want children; get tested, know your status, and then be faithful.
(Thabo, a 28 year old male)

In the end you work on the risk reduction plan, which is either abstain or to use protection. We also ask them who would be the person they could disclose to. Not only when they test HIV positive, but also when they

test HIV negative.
(Phazamisa, a 28 year old male)

However, not every HIV counselling and testing programme recognizes the importance of counselling. Some testing facilities provide testing without sufficient counselling. I have personally witnessed this. At times this was a result of the policy of the institute providing the testing, and at other times this was a result of individuals being too casual about their job. I am not the only one who noticed this:

> The problem is that they do not take their time to talk with the clients. They just explain what the results mean and then they do the test. If they have to be there 45 minutes [according to their protocol] they will just sit quietly waiting for the time to pass. I had this boy come up to me one day asking me what his status was. I asked him if he had been tested. He told me that yes he was tested, but they had not told him the results. I was shocked. I ended up taking the boy into my room to test him again and gave him his results.
> (Nozipho, a 32 year old female)

I argue that in this case the preventative impact will be severely reduced, and I therefore stress the importance of quality counselling when suggesting HIV counselling and testing as a prevention tool.

The final way in which HIV counselling and testing can be a prevention tool is that in certain relationships it might enforce accountability. Sibongile spoke about how she wanted to see her partner's HIV status on paper, and how she would make him get tested every three months. When an individual knows that testing is coming up he or she might reconsider having multiple partners, or might chose to use protection when they are involved with multiple partners. Sibongile refers to having proof and suing her boyfriend if she becomes HIV positive. In the end this is unlikely to hold up, but it makes Sibongile feel some level of control and might make her boyfriend feel that he is being watched, so he has to be more careful.

8.2.2 Previous barriers to getting tested

Despite the great impact HIV counselling and testing could have on preventing HIV transmission, initially HIV counselling and testing was not very popular. In South Africa, despite widespread availability of HIV counselling and testing services, it was estimated that in 2005 less than a quarter of HIV infected people were aware of their HIV status (Abdool Karim & Abdool Karim, 2005: 570).

Stigma was a big barrier and kept people from getting tested. People feared isolation, a 'social death', if others found out that they were HIV positive (Niehaus, 2007). They worried that staff at the clinic would tell people in the community. I found that this had also been an issue in the community in which I was staying. My host-brother told me that he knew the HIV positive status of several people in Faras, because when they were tested at their local clinic the nurse did not keep the results confidential. He made it sound as if this happened a while ago, but having such an experience or hearing rumours about such an experience can have long lasting effects. Dingane also spoke of poor privacy at the clinics. He remembered an occasion when he was sitting in the waiting room when a nurse yelled loudly "all the people that are here for ARV's, please sit on this side". This meant that all the other patients could see exactly who was HIV positive. As a result, some people traveled to other areas to go to the clinic, eventhough officially people had to go to the clinic that was closest to them.

Involuntary disclosure does not always happen in such a direct manner. Steinberg described an incident in 2005 when Médecins Sans Frontières (MSF) set up a mobile HIV counselling and testing facility at a school in a rural community in the Transkei. His participant told him that the community found out that day who was HIV positive and who was HIV negative. This was not because the clients or the counsellors had disclosed their status, but because the onlookers could tell from the length of time the clients spent with the counsellor. Whereas the pre-test counselling would take the same amount of time for everyone, the post-test counselling would be quick if someone was HIV negative, but would take a long time if someone was HIV positive. Based on this experience Steinberg's participant decided that if he was ever going to do an HIV test, he would do it in a place where the people did not know him (Steinberg, 2008: 30-33).

Besides the stigma and confidentiality issues, another factor that made testing unpopular was that there was no cure for AIDS. People preferred not knowing, over being handed a death sentence: "living with a probably/but uncertain belief that one might be harbouring the dreaded HIV/AIDS virus was perceived by the vast majority to be preferable to knowing that one was HIV seropositive" (Leclerc-Madlala, 1997: 368). Almost fifteen years later the HIV pre and post-test counsellors still spoke of people rather not knowing their status:

> People are worried about testing. As if it will be the end of the world if they test positive. It is hard work to make people see that it is not the end of the world. They seem to think that you cannot do anything anymore after testing HIV positive. (…) I have always said that if I have HIV, I would not keep it a secret. When you keep it a secret it is like it is a death sentence. But it is not.

(Sindisiwe, a 25 year old female)

More recently with ARV treatment becoming openly available this perception has slowly started to change. An HIV positive result was no longer perceived as a direct death sentence. The medication could keep the virus under control for a lengthy period of time. As a result ARVs reduced the stigma attached to HIV and AIDS. Phakathi, Rooyen, Fritz, and Richter (2011) found in their research that it had made people see that there is life after diagnosis.

8.2.3 The promotion of HIV counselling and testing

In April 2010 President Zuma launched a massive HIV counselling and testing campaign that aimed at getting 15 million South Africans tested over a period of 15 months. To promote this campaign President Zuma took a public HIV test (see Figure 24). He encouraged other South Africans to follow his example. In response to his request Health Minister Dr Motsoaledi (see Figure 25) and other politicians, councillors, religious and traditional leaders also took HIV tests (Khumalo, 2010). In his speech Zuma aimed to motivate the public to play their part in fighting the HIV epidemic. As part of Zuma's campaign HIV counselling and testing was made available at all public health facilities in South Africa and everyone attending a clinic or a hospital would be offered an HIV test. Although strongly encouraged, the test remained optional. Prior to this campaign, HIV counselling and testing at the clinics was referred to as Voluntary Counselling and Testing (VCT). Zuma's campaign changed this name to HIV Counselling and Testing (HCT). Zuma emphasised that HIV counselling and testing was confidential and private. Furthermore, he stressed that due to the treatment that was available, HIV positive results no longer had to be seen as death sentences. He finished his speech on the following note: "we must all play our role to fight the epidemic" (Zuma, 2010b). In an attempt to fight stigma and to promote openness, President Zuma decided to disclose his HIV negative results a few weeks later. It was his fourth HIV test and he explained that he went for HIV tests regularly. President Zuma highlighted the prevention side of HIV counselling and testing by explaining that besides identifying people who are HIV positive, more importantly HIV counselling and testing helps to identify those who are HIV negative. So that they can be provided with the tools and the information to remain HIV negative (Zuma, 2010a). The campaign proved to be successful when 15 months later 13.5 million South Africans had been tested (Zuma, 2011). In December 2013 Deputy President Motlanthe took a public HIV test on world AIDS day (see Figure 26). Together with Motsoaledi he

introduced an HCT campaign specifically aimed at parliamentarians and parliamentary staff. Motsoaledi argued: "society must see that their leaders are serious about this" (Bodibe, 2013).

Figure 24: Press photo of President Zuma taking a public HIV test in 2010 (South Africa Info, 2010)

Figure 25: Press photo of Health Minister Motsoaledi taking a public HIV test in 2010 (The New Age, 2013)

Figure 26: Press photo of Deputy President Motlanthe taking a public HIV test in 2013 (Bodibe, 2013)

8.2.4 The success of HIV counselling and testing in comparison to condom use

"A valuable lesson that this country has learned is that political leadership is key in efforts to tackle the epidemic" (Bodibe, 2013). In the HIV counselling and testing campaign key

politicians led by example, something that has not been the case when it came to condom use. The only time condoms were mentioned in connection to President Zuma's personal behaviour it was in regard to his lack of condom use. His sexual behaviour came to the world's attention in 2006 when Zuma was accused of raping a family friend who was known to be HIV positive. Zuma was eventually acquitted. During the trial he mentioned that despite knowing her HIV status, he had not used a condom. Instead, to reduce his chances of HIV infection, he had taken a shower directly after intercourse (Decoteau, 2013: 146, 147). With this statement he implied that he rejected condom use, which added to years of confusing messages regarding HIV/AIDS and condom use by the South African government. I argue that this is partly to blame for why talking about condoms is experienced as complicated by couples. For the same reason, the clear leadership shown by President Zuma, the Deputy President and the Health Minister when it came to HIV counselling and testing years later, has contributed to the success of the testing campaign. The aim of Zuma's HIV counselling and testing campaign, which was re-launched by Motlanthe, was to make HIV counselling and testing the norm (Bodibe, 2013). In the beginning people had to go out of their way to get an HIV test, but the launch of HCT aimed to make saying no to testing a bigger effort than getting tested. When HIV counselling and testing becomes the norm, it is easier for an individual to go for a test, or to suggest HIV testing to their sexual partner. Having high ranking politicians willing to test reduces the stigma around HIV counselling and testing and shows that there are no concerns around confidentiality.

The level of commitment from politicians is not the only factor that has made HIV counselling and testing a more popular HIV prevention strategy than the use of condoms. There is also a big difference in the timing of the intervention. Condoms need to be used during the sex act, a context in which women can generally exert little control. Yet HIV counselling and testing can be negotiated outside the bedroom before a couple has even started to become sexually active. For a woman it could be one of her 'terms and conditions' before she *ukuqoma* (chooses her lover). In chapter 6, on initiating sexual relationships, I have stressed that this is the time that women have most control. Furthermore, condoms are perceived as interruptive, they make flesh to flesh contact impossible, they work as contraceptives, and they have the potential to kill the romantic aspect of the sexual experience by directly linking sex to HIV. This is in contrast to HIV counselling and testing which, because it can take place long before the sexual act, does not have these same negative 'side-

effects'. Hence the timing of the intervention works in the favour of HIV counselling and testing over condom use.

Due to the window period and the uncertainty around exclusiveness in a relationship, HIV counselling and testing cannot offer the same level of protection as condoms. However, if condoms are not being used, HIV counselling and testing is the second best outcome. For the reasons mentioned above, it is easier to negotiate HIV counselling and testing than it is to use condoms. Although it is questionable that Sibongile spoke to her boyfriend as directly as shown in the introduction of this section, she has found a way in which she lets her boyfriend choose between the use of condoms or regular HIV counselling and testing. Another participant, Sindisiwe, also mentioned to me that she goes for regular HIV counselling and testing with her boyfriend:

Sindisiwe: I like the testing. Every three months me and my boyfriend get tested together. We go to Thandi. She is a tester at the clinic here in Faras. She is the sister of my sister's friend. She is young. She will say: "Hawu [surprise] You again"? "Just to be sure", I will tell her.

Eva: So you and your boyfriend can talk about this [HIV testing]?

Sindisiwe: Yes we can. We are like friends. We have been together for eight years now. We can talk about anything.

Eva: What about the first time?

Sindisiwe: This was after life orientation. We were sitting next to each other in this class. After hearing the teacher speak about this [sex], it caused us to have sex. "What is this that she is talking about, we must experience it". The first time we had sex, we did not use a condom. So then we had to experience this other thing that she [teacher] was talking about; HIV testing.

When Sindisiwe refers to the communication between her and her boyfriend she mentions they can speak about these matters because they are *like* friends. This is similar to what I have observed in chapter five when parents want to talk to their children about HIV prevention, but they are not supposed to do so in their position as parents. To get around it they temporarily change their subject position by acting *as if* they were peers or siblings. Sindisiwe also refers to HIV counselling and testing as an exciting new experience, something that is not often said about condom use. It might be that this is how she gets her boyfriend to decide that HIV counselling and testing is a good idea, as he is likely to still be the one making the decisions.

As a result of the gender inequality, discussed in chapter six, it is unlikely that these women demand that their partners are tested; instead their approach is likely to be more discreet. They might merely inform their partner that they themselves are being tested. This is

what Amukelani told me she would do when she was to start a new relationship. After a month she would bring up the topic of HIV counselling and testing. She would tell her partner: “I have had an ex, do you mind if I would go for my test? Maybe you want to come with me for support?” This shows how she avoids telling him what he should do. She positions herself as submissive and hopes that this way she can get his cooperation. Amukelani explained to me that she could not ask him to go for a test, because that is up to him. Yet she would like it if he did go for a test. In this humble manner she suggested a small change. It was a compromise; structural factors kept her from directly demanding that her sexual partner would go for an HIV test, but within her limited options she chose the option that had most potential to reduce the risk of HIV transmission. Hence she introduced change that is within reason. As the conceptual framework in chapter two explained, Amukelani has internalised her position in the field. As a result of habitus, she is unlikely to have aspirations outside these restrictions. Amukelani found the best solution within her power.

8.3 Medical male circumcision

From 1989 onwards several studies established that there is a correlation between low rates of male circumcision and high rates of HIV infection (Caldwell & Caldwell, 1994: 30; Marck, 1997: 338; Riegelman, 2012: 24; Scott et al., 2005: 305). This correlation is clearly visible when comparing Figure 27 and Figure 28.

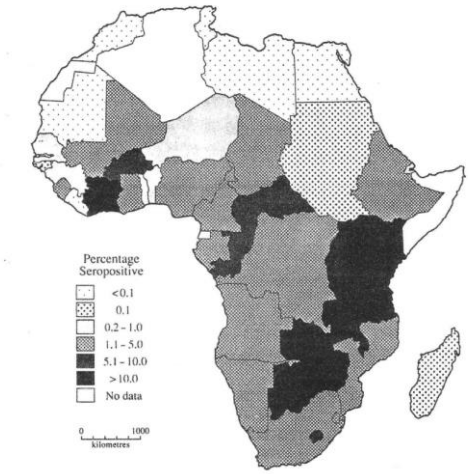

Figure 27: Map indicating HIV prevalence for low-risk urban populations in 1993 (Caldwell & Caldwell, 1994: 24)

Figure 28: Map indicating ethnic groups that generally do not practice male circumcision (Caldwell & Caldwell, 1994: 29)

Despite the early detection of the correlation, Caldwell and Caldwell (1994) argue that it took numerous years before these findings were seriously considered. In 2003 a randomised clinical trial was started in Johannesburg, South Africa, to establish if circumcision indeed provided HIV prevention (Barnett & Whiteside, 2006: 363). This was soon followed by two more trials in Rakai, Uganda and in Kisumu, Kenya (Riegelman, 2012: 25). The conclusion of these trials was that medical male circumcision reduces a man's risk of HIV infection in heterosexual relationships by 50-60 percent (Grund & Hennink, 2011: 245; J. E. Mantell et al., 2013: 112; WHO/UNAIDS, 2007: 11). At this stage it is unclear if circumcision also reduces the risk of an HIV positive male transmitting the virus (J. E. Mantell et al., 2013: 112).

The fact that male circumcision is not without risk becomes evident from the newspaper articles published0 when circumcision camps are held in the Eastern Cape during the summer and winter school holidays. The following is just one example:

> JOHANNESBURG – Botched circumcisions killed 30 young men and landed almost 300 more in hospital during traditional initiation rites in a South African province, the Health Department said Sunday. The 30 deaths in rural Eastern Cape Province occurred during the annual season when young males undergo a rite of passage into manhood. Ten other youths were hospitalized after being rescued from a forest on Sunday, said Provincial Health Department spokesman Sizwe Kupelo in a statement. "The ten initiates' private parts are rotten. They are badly damaged. Their condition is scary," he said. A further 293 young men were undergoing hospital treatment for dehydration, gangrene and septic wounds, Kupelo added. Some had lost their genitals (Inquirer, 2013).

These deaths and lasting injuries, an exception when considering the large number of boys that attend circumcision camps every year, are the result of a combination of unqualified medical practitioners and hardship endured by the young men during the camps which last several weeks. This malpractice requires attention, however, the circumcision referred to in this thesis differs from these Xhosa circumcision camps discussed in the media. This thesis looks at medical male circumcision taking place at either government-run or private medical clinics.

8.3.1 Medical male circumcision as an HIV prevention strategy

Medical male circumcision serves as an HIV prevention tool in several ways. First of all the procedure has a preventative impact of fifty to sixty percent because the inner lining of the foreskin contains large numbers of white cells, HIV target cells, in close proximity to the surface and is susceptible to abrasions and tears. Furthermore uncircumcised men are at greater risk of ulcerative lesions, which increases their risk of HIV infection (Riegelman, 2012: 26).

Removing the foreskin is not the only part of medical male circumcision that makes it an HIV prevention tool. In comparison to young women, young men attend the medical clinic less often. This means that medical male circumcision can offer the rare opportunity to provide young men with health messages. Furthermore, the procedure at the medical clinic does not only involve the removal of skin, but also involves HIV counselling and testing. Ulwazi states that "medical male circumcision kills two birds with one stone". Not only are the men being circumcised, they are also being tested and as the previous section has argued HIV counselling and testing has a positive effect on HIV prevention. In addition, when men present obvious symptoms of STDs during the medical male circumcision procedure they are referred to a doctor. STDs increase susceptibility to HIV infection by two to five times (CDC, 2010), because genital ulcers cause breaks in the genital tract lining or skin allowing HIV to enter. Inflammation also increases the concentration of CD4 cells in genital fluids, which can serve as targets for HIV. Finally an STD increases the infectiousness of a person who is HIV positive. This can be explained by the fact that STDs increase the frequency and the amount of HIV found in genital fluids, which in turn increases the chances of HIV transmission (CDC, 2010). Hence, for all these reasons the treatment of STDs reduces the risk of HIV transmission.

The current medical male circumcision provided in KwaZulu-Natal, pays little attention to cultural elements. Khethiwe told me that she had invited traditional healers to visit the

medical clinic in Faras to bless the clinic and make it an acceptable location for circumcision to take place. Since then up to 200 boys were circumcised at the clinic in Faras every weekend. Prior to the procedure, boys underwent HIV pre and post-test counselling and an STD check. They also received information about wound hygiene, the necessary six week abstinence from sex, and the importance of condom use despite being circumcised. What is not part of medical male circumcision, but is a large part of the Xhosa circumcision camps, are discussions about masculinity. The camps used to be rites of passage which transform boys into men. During the camps men are taught how to act as responsible men and how to treat a woman. Adding this element to the contemporary practice of medical male circumcision could mend the existing gap in sexual socialisation that has been identified in chapter five, creating another way in which medical male circumcision could reduce the risk of HIV transmission.

8.3.2 Criticism on medical male circumcision

A first concern is in line with the content of the newspaper article quoted earlier. To avoid infections or complications as a result of the procedure, it was decided that medical male circumcision had to take place in hygienic settings with qualified medical practitioners approved by the Department of Health (Riegelman, 2012: 27; WHO/UNAIDS, 2007: 13).

Directly after circumcision a man has to refrain from sexual intercourse for six weeks to allow the wound to heal. During these first six weeks the risk of HIV infection has actually increased due to the open wound (Riegelman, 2012: 27; WHO/UNAIDS, 2007: 12). A second concern is related to this period of abstinence as some of the earlier research indicated that up to 17 percent of circumcised men did not abstain for the full six weeks (Matovu et al., 2007: 73).

However, the biggest concern is that medical male circumcision might demotivate condom use. Critics worry about risk compensation; meaning that men present riskier sexual behaviour, because they believe that medical male circumcision has made them immune to HIV infection. Despite circumcision reducing the risk, it does not eliminate the risk completely. It becomes dangerous when people think it has (Berer, 2007: 45; Grund & Hennink, 2011: 245-250; J. E. Mantell et al., 2013: 112; Matovu et al., 2007: 68; Riegelman, 2012: 30; WHO/UNAIDS, 2007: 11). I spoke to several people who expressed their concern that the promotion of medical male circumcision would demotivate condom use. Ntokozo, a funding coordinator at Oxfam, is one of these people:

> I do not support the promotion of medical male circumcision. It will be another confusing message. It will incorrectly give people the idea that they are protected and that they therefore do not have to use a condom anymore. This will make it even harder for women to suggest the use of a condom.
> (Ntokozo, a 40 year old female)

Sibongile was thinking along the same lines as Ntokozo when she told me:

> Male circumcision is so popular because young men think that they will be protected against HIV. That they no longer need to use a condom. They think they are safe, but they are not. Although the risk has reduced, they are not safe, but this is not clear. I do not want to support strategies that are not 100 percent safe.
> (Sibongile, a 49 year old female)

When I voiced these concerns to Khethiwe, the initiator of the 'Bafana AIDS Project' and later also the person behind the medical male circumcision trial in Faras, she responded:

> I think today, they are not using condoms anyway. That is the thing. We are promoting circumcision, but we still say that even then they must use a condom. But we know they are not using condoms. So for me that is not a major issue. We know that at least somehow between sixty and eighty percent they will be protected. So that is what we are doing.
> (Khetiwe, a 55 year old female)

Although there is the risk of creating a false feeling of safety by promoting medical male circumcision, Khethiwe suggests that if people are not using condoms anyway, the protection that circumcision provides will be better than no protection at all, a view that is supported by Scott (2005: 312) and Mantell (2013: 115).

8.3.3 The promotion of medical male circumcision

Despite these concerns, the WHO decided to recommend medical male circumcision as an HIV prevention intervention for adolescents (Berer, 2007: 46; Riegelman, 2012: 25-28; Scott et al., 2005: 304; WHO/UNAIDS, 2007: 11, 12). In South Africa the medical male circumcision campaign was launched in KwaZulu-Natal in April 2010 (Department of Health, 2010a; J. E. Mantell et al., 2013: 112). KwaZulu-Natal was chosen as the first province to trial medical male circumcision, because it was the province with the highest HIV prevalence and male circumcision was not commonly practiced there, see Figure 28. It was therefore thought that if medical male circumcision would have an impact it would be clearly visible (WHO/UNAIDS, 2007: 13).

Together with the Premier of KwaZulu-Natal Zweli Mkhize, President Zuma had asked the Zulu King to launch the medical male circumcision campaign. So it was King Goodwill Zwelithini who officially introduced medical male circumcision as an HIV prevention strategy. The King promoted medical male circumcision as a 'revival' of the 'historical' practice of male circumcision (Decoteau, 2013: 148; Dugger, 2010). To further aid the promotion of medical male circumcision President Zuma spoke publicly about being circumcised himself and that he had recommended that his sons should be circumcised too (Decoteau, 2013: 148). He chose to make this information public, because he thought it "could help quite a few other people who, if I did not do it, would be hesitant and not knowing what to do" (Dugger, 2010). Also part of the campaign was the hands on approach of the Premier of KwaZulu-Natal Zweli Mkhize, the Minister of Health Aaron Motseoledi, and the Member of Executive Council for Health Sibongiseni Dhlomo. The three of them are all respectable politicians and qualified doctors. In July 2010 they returned to the operating table for a day and helped a team of doctors circumcise young men at a circumcision camp (Department of Health, 2010b).

Within a month of the King launching the campaign, I witnessed how young men were standing in line at the clinic to get circumcised. Talking to different players in the field in 2010 I was under the impression that the campaign was successful. The hospital in Greytown had a waiting list for circumcision, the circumcision clinic in Pietermaritzburg always seemed to be packed with young men, and the camps organised by the Reproductive Health and HIV Research Unit (RHRU) had to turn young men away for their camps that accommodated 200 men each time. My observations are supported by several sources that reported the success of the circumcision campaign (Radio Nederland Wereldomroep, 2010; UNAIDS, 2013). Between 2011 and 2013 more than 300,000 men were circumcised in KwaZulu-Natal. The executive director of UNAIDS Michel Sidibé has applauded the Premier of KwaZulu-Natal for successfully implementing the medical male circumcision programme (UNAIDS, 2013).

8.3.4 Explanations for the popularity of medical male circumcision

It was surprising to me to see that an intrusive intervention like medical male circumcision could be so popular. I argue that its popularity can be explained by the following factors. First, in a similar way to the promotion of HIV counselling and testing, different political and cultural leaders, including the Zulu King, became involved in promoting medical male circumcision; some were even involved in the actual circumcision of young men. It was an example of clear leadership. Instead of distancing themselves from this practice these

politicians and the Zulu King took ownership of this campaign and represented it well. As a result the level of confusion around this HIV prevention strategy, which had been rife around condom promotion, was minimal.

Second, in a similar way to HIV counselling and testing, the timing of medical male circumcision is more convenient than that of condom use. From an HIV prevention perspective ideally young men are circumcised prior to becoming sexually active. The minimum age for circumcision is sixteen. It is a once-off inconvenience. It does not impact the sexual activity and therefore does not spoil the experience of sex by linking it to HIV. Furthermore, whereas condom use and HIV counselling and testing as a couple require dialogue, men can implement medical male circumcision on their own. This is an important benefit in a context in which sexual negotiation is limited.

Third, whereas condom use has been negatively associated with pleasure, medical male circumcision has been positively associated with pleasure. There is a widespread rumour that women prefer to have sex with a circumcised man. Dingane was the first to tell me that young men think that women prefer a circumcised man over an uncircumcised man. Khethiwe repeated this same rumour:

> Apparently there are rumours that a circumcised man is better in bed. In a discussion I had with a group of men, they suggested that circumcised men take longer to ejaculate. I think that all men want to be better in bed, they do not want to get complaints.
> (Khethiwe, a 55 year old female)

Ulwazi was familiar with the same rumour. He mentioned that his wife had told him he should get circumcised, as she had heard rumours that circumcised men are better in bed. This rumour was quickly adopted into flirting strategies. One day Thabo looked at me with his flirting smile and suggestively whispered: “I am circumcised”. Furthermore, condom use has been linked to emasculation or a blocked masculinity, because there is no flesh to flesh contact, bodily fluids cannot flow freely, and it works as contraception. Male circumcision on the other hand symbolises the transfer of a boy into a man and as such strengthens manliness. The word *isoka* (a man with many lovers, a symbol of tough masculinity) is related to *ukusoka* (to circumcise). Hence young men seem to be peer pressured into medical male circumcision and pressured out of using condoms.

The final reason why medical male circumcision became a popular HIV intervention is because the intervention was generally considered culturally appropriate. This is remarkable

because for the last 200 years the Zulu population identified themselves as the ones who do not circumcise, in contrast to the Xhosa population (McNeil, 2011: 28). Similar to the Xhosa circumcision camps, male circumcision was once part of a lengthy rite of passage among Zulu men. However, in the early nineteenth century King Shaka abandoned the practice, because he needed his young men to fight in his army and feel loyal towards the nation, instead of wasting their time bonding with their community at the circumcision schools (Caldwell & Caldwell, 1994; Hunter, 2010: 51; Marck, 1997: 352). It is for this reason that I argue that the perception of medical male circumcision as culturally appropriate is the result of proactive marketing. By the time that the WHO recommended medical male circumcision as an HIV prevention strategy, it had become clear that the perception of condom use as a foreign solution was partly to blame for its lack of popularity. Hence the organisers realised that the medical male circumcision campaign would stand a better chance of being implemented by individuals if it was perceived as a locally driven initiative and considered as appropriate behaviour. As explained in chapter two, habitus largely inclines the practice of an individual. As a result of structural factors an individual generally practices as he or she in their position is disposed to do. Hence, to get individuals to implement new practices, in this case HIV prevention practices, the collective approval of this behaviour was required. Consequently, the Zulu King was asked to launch the male circumcision campaign (Decoteau, 2013: 148; Dugger, 2010; H. Phillips, 2012: 124). Both the King's support for the intervention and the King's referral to medical male circumcision as a revival of a Zulu 'tradition' made the intervention appear as part of, or innate to, Zulu culture. As has been argued in chapter five, this demonstrates how the concept of 'tradition' can be associated with antiquity without having a solid historical backing. Furthermore, it shows how 'tradition' can be invented as a political tool to manipulate support for a newly introduced practice (Hobsbawm & Ranger, 1983; Spiegel & Boonzaier, 1988).

Besides linking 'tradition' to something that has been established a long time ago, people generally also assume that the particular 'tradition' has not changed since its inception. Yet the contemporary version of medical male circumcision conducted at the clinic is very different from the circumcision schools that existed before Shaka abolished them. More than 200 years ago it was all about the transition of boys into men; now the main priority is HIV prevention. In the past it took place over several days or weeks in a remote location, now it only takes one day in a clinic. Even the exact procedure is different: more foreskin is removed during medical male circumcision than with 'traditional' circumcision. Green et al. (2009)

argue that when the 'revival' of relevant historical practices is suggested this does not necessarily refer to going back in time and reproducing the practices as they once were. Instead they argue that African cultures are flexible and allow for historical practices to be adapted to the contemporary context of the HIV epidemic (E. C. Green, Dlamini, D'Errico, Ruark, & Duby, 2009: 390). This seems to be exactly what has happened to the 'tradition' of male circumcision. The practice promoted today bears only small resemblance to the practice that once was and the past 200 years male circumcision had no place in Zulu culture. Hence the ancient practice has been adapted to the current context, showing how change is masked under the heading of 'tradition'.

8.4 *Ukuhlolwa kwezintombi* (virginity testing)

Sindisiwe invited me to meet her friend, Thuleleni. Together they work as volunteers for the Red Cross in Faras. Whilst Thuleleni was hosting us at her house, she showed me her photoalbum. Several of the pictures showed Thuleleni in an outfit made out of beads, limited to a small skirt and a broad necklace. Her breasts were uncovered. Thuleleni explained that these pictures were taken during a virginity testing ceremony at the community hall in Faras. As a teenager Thuleleni, who is now 23 years old, was part of a group of young women who regularly had their virginity tested. When Thuleleni was 18 years old she became pregnant, which meant she had to leave the group. She now has two children outside wedlock and is no longer together with the father of her children. Through her photoalbum Thuleleni introduced me to the topic of virginity testing, which I came to find out had been practiced by several of the women I met during my fieldwork. This section explains the concept of virginity testing and discusses the recent revival in an attempt to address youth sexuality, particularly pregnancies outside wedlock and HIV prevention.

In 1994 Andile Gumede and Nomagugu Ngobese started to bring groups of young women together for *ukuhlolwa kwezintombi* (virginity testing) in the greater Durban area (Scorgie, 2002: 57). "Their aim was to empower young women, but also to contribute to the development of self-respect, self-esteem, and pride in Zulu people" (Kaarsholm, 2005: 146). This way it was believed that "virginity tests would help to combat rape, teenage pregnancies and the spread of HIV/AIDS and sexually transmitted diseases" (Kaarsholm, 2005: 147). They made virginity testing into a public affair; at times filling sport stadia with virgin maidens. Men were banned from these events. The ceremony started with speeches in which the young women were encouraged to delay their sexual debut (Wickström, 2010: 536). This was followed by the actual virginity testing. The young women, who were bare breasted,

wearing 'traditional' Zulu skirts and who were adorned with beadwork, lay down on their back on grass mats. When the *umhloli* (examiner) sat down in front of them they spread their legs. The *umhloli* used her hands to part the woman's labia and had a quick look at the woman's genitalia (Scorgie, 2002: 58). To determine if the woman was still a virgin the *umhloli* looked for the following: the colour of the labia should be a light pink, the size of the vaginal opening should be small, the vagina should be dry and tight, and the white dot or white lacy veil should be visible and intact (Leclerc-Madlala, 2001b: 540). As signs of virginity the *umhloli* also inspected the muscle tone of the young woman, her buttocks and breasts should be firm, not flabby and her abdomen should be flat and taut (Scorgie, 2002: 59). Furthermore, she looked the young woman in her eyes, if the woman was no longer a virgin, her eyes would give away that she "knows men" (Leclerc-Madlala, 2001b: 540).

Scorgie (2002) and Leclerc-Madlala (2001b) describe that when a young woman passes as a virgin she is given a dot of white clay on her forehead. This is greeted with cheers and ululating from the onlookers and for a small fee she can collect a certificate stating her virginity status. What happens to the women who fail the test is described differently by Scorgie and Leclerc-Madlala. Scorgie indicates that the *umhloli* makes an effort not to stigmatise these women. Instead she takes these women aside to find out if they had intended to have sex or if they had been abused. In case of the former she reminds them of the risks of pregnancy, STDs and HIV, and tells them it is not too late to live as virgins (Scorgie, 2002: 58). In case of the latter she refers them to places where they can get support (Wickström, 2010: 536). Leclerc-Madlala's description of those who fail is linked to shame and disgrace. Consequently those who fail need to be separated from the virgins as the *umhloli* considers them a bad influence on the virgins (Leclerc-Madlala, 2001b: 540). Although it happens that young women fail the test, Wickstrom argues that the *umhloli* prefers not to find failure. The ceremony is aimed at confirming and celebrating virginity. For this reason, prior to the testing the *umhloli* advises those who have boyfriends to go home (Wickström, 2010: 535, 541). When all the women are tested, the virgins celebrate with singing and dancing competitions.

Although the public testing has gained popularity in the last two decades, private testing is not uncommon. A 23 year old participant tells me how, whilst growing up, she was regularly tested at home by her own *gogo* (grandmother), who is a *sangoma* (spiritual healer):

> Sindisiwe: It [virginity testing] is good, but mothers should not force us. In that case girls are doing it for their mothers, not for themselves. (…) Our *gogo* used to do the testing.

Eva: You mean she was testing the girls in the community, or she was testing only the girls in your family?

Sindisiwe: She was only testing us. Every Sunday we would have to come outside behind the house. If you had not gone to see her, she would be asking if you had something to hide. One day it just stopped. I think that maybe she had seen something with one of my older sisters.

Evidently, from a biomedical point of view the validity of the test can be questioned, but validity is ultimately irrelevant. This practice is part of the reality of several of the participants and it is valuable to understand what it means to them. Despite serious attempts I have been unable to attend any virginity testing ceremonies. As a result the information described here is a combination of literature and information provided to me by the participants. In this section I argue that the practice of virginity testing has gained popularity quickly. This is not to suggest that every young Zulu woman is part of a virginity testing group. There are plenty of young women who do not agree with the practice and the majority of the female participants did not have their virginity tested:

> I do not believe in it [virginity testing]. Although it is my culture and I respect my culture. I do not believe in virginity testing. I was not raised this way. My family does not do this.
> (Amukelani, a 32 year old female)

8.4.1 Virginity testing as an HIV prevention strategy

The practice of virginity testing promotes the delay of sexual debut. Obviously those who refrain from sexual activity are protected from sexually transmitted HIV infection. As indicated in chapter five on sexual socialisation, among the older generation there has been a feeling of powerlessness as they watched on while an increasing number of young people became pregnant outside wedlock and were affected by HIV/AIDS. They believe that the sexuality of young people is out of control and that 'traditional' morals around dignity and abstinence are disappearing (Leclerc-Madlala, 2001b: 535; Scorgie, 2002: 20, 62). The older generation reminisces nostalgically about their own years as adolescents when according to their memories the youth were kept tightly under control (Leclerc-Madlala, 2001b: 537; 2003: 16). There were structures in place that provided sexual socialisation and that monitored sexual behaviour, which guided the youth through their adolescent years. The elders believe that these structures need to be reinstated. They suggest that practices like medical male circumcision and virginity testing can provide valuable platforms for sexual socialisation as they provide the opportunity to both educate and monitor the youth (E. C. Green et al., 2009:

395; Leclerc-Madlala, 1999: 160; 2003: 23; Marcus, 2009: 536; Scorgie, 2002: 62). Just as medical male circumcision involves more than the removal of skin, virginity testing involves more than the inspection of the hymen (Leclerc-Madlala, 2003: 20; Wickström, 2010: 535). One of the participants affirms this:

> Virginity testing is not purely about testing if the girl is still a virgin. This is a moment in which there is time to care about the girl's well-being; a moment for [HIV] awareness and getting the knowledge out there. (Sibongile, a 49 year old female)

According to the descriptions in the literature, the girls who were involved in the testing were organised in groups which each had a slightly older group leader. These groups regularly came together in preparation for the testing ceremony. As a group they discussed the importance of delaying sexual debut to prevent pregnancy and STDs (in particular HIV transmission) and as a group they supported each other as they dealt with the challenges of adolescence (Marcus, 2009: 540). In these groups the young women also discussed how to deal with the peer pressure of becoming sexually active, what to do when experiencing love, and the struggle of declining love proposals from men. The young women were taught to know their own boundaries and how to say no. As they gained sexual assertiveness, they learned to be in control of their own lives (Scorgie, 2002: 67, 68). The young women said that the virginity testing gave them a feeling of *ukuqhenya* (show pride) and *isithunzi* (dignity) and had boosted their self-esteem (Marcus, 2009: 539; Scorgie, 2002: 64; Vincent, 2006: 23; Wickström, 2010: 537). They made life plans and encouraged each other to follow them through. By being part of a group of likeminded women, they felt supported in their lifestyle choice. It created a sense of solidarity and made it easier for these women not to give in to the pressure to become sexually active (Leclerc-Madlala, 2003: 20; Scorgie, 2002: 65).

Women took great pride in remaining virgins. Nozipho's 19 year old sister Andile was also part of a virginity testing group. She proudly showed me something that she had drawn herself. It was a red AIDS ribbon with the words: "say no to sex". I believe the virginity testing groups empowered young women by making them feel that they were in control of their lives. The following examples show that the emphasis on the importance of virginity encouraged young women to prioritise education over sexual relationships. Nokwethemba was Nandi's 15 year old cousin and I met her when I visited Nandi at her home. While we were washing the dishes Nokwethemba told me that she was still a virgin. She told me that she had an agreement with her mother; if she remained virgin until she finished Matric (the

final year of high school) then her mother would pay for her to study overseas. Nokwethemba was a very confident, outspoken young woman. She had clear plans for her future. She wanted to become a politician or a lawyer and she described sexual relationships as a distraction. This idea resonates with Vusi's and Nondumo's 21 year old sister. She was the only sibling who was still a virgin. She was also the only one who had continued studying after high school. Her parents and siblings had put their money together so that she could study. After completing her studies she was expected to obtain a good job and to support her family in return. Under these circumstances it was important that she would not be distracted by boys. A famous TV presenter summarised this as follows: "books before boys because boys bring babies" (Sbu, 2011).

Gender relations have been a central theme throughout this thesis. The moment a woman chooses a lover her subject position changes. Whilst being courted a woman is in charge of decision making, but after she has chosen her lover her position becomes submissive in relation to that of her partner. Her partner is in charge of sexual decision making and to a certain extent she has to provide him with sex when he makes this request. This places her at risk of HIV transmission. This takes her ability to prevent HIV infection out of her hands. However, as long as she does not get involved, she is able to exert control over her sexuality and therefore prevent HIV infection.

8.4.2 Criticism on virginity testing

The South African Commission on Gender Equality (CGE) and the Human Rights Commission (HRC) condemn the practice of virginity testing because, in their opinion, the practice violates the right to privacy and control of one's body (Leclerc-Madlala, 2003: 20; Scorgie, 2002: 55). This resulted in the passing of a bill in 2005 which prohibited virginity testing of children under the age of 16 (Scorgie, 2006: 24). One of the participants responded to the criticism as follows:

> People can say it is wrong. But just let it be, if you do not want your child there, then just keep her out of there. Do not stop this for other people. As long as it is a girl's own decision (like the daughter of my niece who has asked for it) then there is nothing wrong with it.
> (Sibongile, a 49 year old female)

Leclerc-Madlala has also criticised the practice of virginity testing. She is mainly concerned about the underlying principle of the practice, which is solely focused on women's sexuality.

The responsibility of men is ignored. Women are held responsible for their sexuality, which assumes that women can at all times choose to remain virgin. Yet a considerable number of women are persuaded or forced to have sex. Leclerc-Madlala argues that virginity testing reinforces a sexual double standard and a patriarchal mind-set (Leclerc-Madlala, 2001b: 533; 2003: 16, 23).

I appreciate that the practice of virginity testing singles out women and that by doing so it instigates an expectation that women are in charge of HIV prevention, even though, as this thesis has shown so far, it is generally the men who are in charge of sexual decision making. However, the women I spoke to who were or had been members of virginity testing groups described the practice as empowering. They could maintain control over HIV prevention by avoiding getting involved with men. Furthermore, there are other practices that attend exclusively to men and place the responsibility of HIV prevention with them. Medical male circumcision is an example of this. To some extent this restores the equilibrium by also placing responsibility on men for prevention of HIV transmission.

8.4.3 The promotion of virginity testing

In response to the HIV epidemic Goodwill Zwelithini reintroduced *Umkhosi Womhlanga* (royal reed dance ceremony) in 1991. The ceremony was to encourage young Zulu girls to delay sexual debut until marriage (McNeil, 2011: 27). The annual event celebrates virginity and only 'certified virgins' are allowed to participate (Vincent, 2006: 17). Every year in late August or early September the King invites Zulu maidens out to his royal residence in Nongoma (Miya, 2011). Free buses are sent to towns and rural areas all over KwaZulu-Natal to pick up willing participants (Mncube, 2011). The maidens arrive late on Friday, on Saturday the main event takes place, and on Sunday morning they travel home again. The popularity has been growing over the years and when I was in South Africa in 2011 more than 30,000 young Zulu women participated in the ceremony (Miya, 2011).

Thabo introduced me to his neighbour Mbali who was 21 years old and lived in a township near Pietermaritzburg. She and her cousin Busi did everything together, except that Mbali attended the royal reed dance ceremony, whilst Busi did not. Busi told me that she did not agree with "this thing" - referring to virginity testing. Mbali on the other hand became enthusiastic when she was given the opportunity to talk about the virginity testing practice. She even dressed up in the outfit that she and other members of her group wore when they attended the reed dance. She warned me that in her group they showed a lot of skin. Her outfit consisted of a short skirt and a wide necklace made out of white beads, leaving her breast

bare. She also wore a bracelet around her upper arm and ankle made out of the same beads. Mbali described the royal reed dance as a great opportunity to meet other like-minded women. The reason why she sincerely enjoyed this was because the people in her community sometimes made fun of her. Instead of being interested in boys she was interested in doing well at school, because she aspired to become a lawyer. Her peers did not always understand why she found it important to abstain. However, at the reed dance she met women who were like her. Mbali described the royal reed dance ceremony as an exciting event that started with a long journey on the bus arriving in Nongoma late at night. They slept on the bus. The next morning they washed themselves in the river before they dressed up in their outfits made of beads. The maidens were then led by the king's daughters as they presented the King with a reed (see Figure 29). The reed symbolised their purity (Miya, 2011). Several participants told me that the women were scared to break these long reed sticks, because a broken reed was understood to represent a false virgin. When all the reeds were placed on a pile, the King delivered a speech. This was followed by singing and dancing competitions. Mbali told me that in the afternoon there was time to talk to the journalists and to socialise with the other groups of girls from all over the province. At night there was a party, but their 'Mam' (a slightly older woman who looks after the group) warned them to stay together, as this was the time when men were known to come out to make contact with the virgins.

Figure 29: Press photo of the Royal Reed Dance ceremony in 2011 (Sowetan 2011)

Several political leaders expressed their support for virginity testing when they attended the reed dance. KwaZulu-Natal Premier Dr Zweli Mkhize stated that the event creates "a platform to enable honest discussions about issues relating to sex and sexuality" (Zuma, 2011). President Zuma said: "The ancient practice of virginity testing is a viable solution to curbing the spread of HIV/AIDS and teenage pregnancy" (Tyali, 2004). The government, more particularly the Department of Arts and Culture, also helped the King to organise the reed dance. For example to guarantee the safety of the young maidens the government was in charge of transport. This way they could control the maximum number of girls attending the ceremony and they could ensure that the girls returned home before dark on the Sunday (Mncube, 2011).

Despite serious attempts, I have been unable to attend the reed dance. Leading up to the event several participants invited me to join their group and travel with them on one of the buses. These were invitations I gratefully accepted. However, closer to the date it turned out that the buses were full and that even the participants were not sure of a seat on the bus. This suggests that if more buses were made available, the number of young women attending could even be higher.

8.4.4 The strategic use of 'tradition'

E. C. Green et al. (2009) argue that it is important to consult traditional leaders, such as chiefs, members of the royal family, and initiation specialists, when establishing HIV prevention strategies. Up until recently African culture and traditional leaders have mainly been ignored or perceived as obstacles to HIV prevention. The majority of HIV interventions, like condom promotion, have been 'foreign' solutions and have been mainly implemented without taking the local context into account. This thesis has taken the time to describe a local context characterised by a lack of sexual socialisation (chapter five), gender inequality, a challenged masculinity, transactional relationships (chapter six), and an apartheid-inherited suspicion of western initiatives (chapter seven). By working with traditional leaders and listening to the people 'on the ground', internationally funded interventions can find out which solutions could have a place in this particular local context. E. C. Green et al. (2009: 389-392) argue for a 'culture-positive approach' and consider Uganda's HIV prevention programme, discussed in chapter three, as a prime example. The alternative interventions central to this chapter are another example. HIV counselling and testing, medical male circumcision and virginity testing have been perceived as locally driven. These interventions have generally been perceived as the appropriate thing to do. Chapter two has discussed the

concept of habitus and how individuals generally do what people in their position are disposed to do. Hence when certain practice is socially approved, individuals are encouraged to implement the practice. The opposite is true for practice that is condemned, in that case the same structural factors discourage an individual from implementing it. I argue the latter was the case with the practice of condom use.

It is suggested that in the pre-colonial past virginity testing was widely practiced. This period is often described as pure and stable (Scorgie, 2003: 64, 65). Subsequently, due to the influences of Christianity, westernization, and urbanisation, and later apartheid, several Zulu practices related to sexuality, including virginity testing, were banned or faded away during white rule (Kaarsholm, 2005: 147; Leclerc-Madlala, 2001b: 536; Marcus, 2009: 537; Scorgie, 2006: 20; Wickström, 2010: 538). Then, in the 1990's, the practice of virginity testing was revived (Vincent, 2006: 17). Several anthropologists have identified an ideology amongst their participants that in response to 'modernity' the transgression of 'traditional' sexual norms (as a result of 'modernity', urbanisation, and capitalism) is responsible for the high level of casual sex. Niehaus, for example, observed amongst his participants that AIDS was experienced as "an affliction unleashed by the transgression of sexual taboos" (Niehaus & Jonsson, 2005: 192). One of his participants stated: "In the past we married, but today the youth have lost their morals. They ignore taboos and screw about. This is why they are dying like ants" (Niehaus, 2007: 852). Ashforth describes a similar attitude among some of his participants who considered AIDS the work of god as a punishment for immorality (Ashforth, 2001: 10). Saethre and Stadler (2009: 269-273) suggest that it is the urban existence that has caused people to lose their culture, arguing that people in town have gradually suspended the enactment of 'traditional' customs (e.g. virginity testing, respecting the elders, and refraining from intercourse prior to marriage). Although some people held on to their 'traditions' and for instance sent their teenage daughters back to their rural family to undergo virginity testing, the majority stopped practicing the customs. The participants in the study by Saethre and Stadler (2009: 269-273) believed that if people still practiced the customs, HIV would not have been able to spread so easily. When carrying through this ideology the solution to 'modern' problems would be to return to 'tradition', and this has been argued by several 'traditionalists' both in response to the HIV epidemic at the end of the 20th century and in response to an increase in premarital pregnancies and venereal disease at the start of the twentieth century. In 1919 Sibusisiwe Makhanya and Bertha Mkhize started an organisation called the 'Bantu Purity League'. The league addressed the moral standards of African girls.

It was a forum in which girls learned that responsible womanhood involved sexual restraint. The aim was to increase women's self-confidence so that they felt in control of their sexuality and therefore would remain 'pure' (avoid premarital sexual involvement). The increase in premarital pregnancies amongst young girls and later also an increase in venereal disease was "a trend that many traditionalists attributed to the decline of pre-colonial rites of passage and the failure of new institutions to replace them" (Healy-Clancy, 2013: 107). As described above, Makhanya and Mkhize also perceived 'modernity' as disruptive to 'traditions' of sexual education. The Bantu Purity League stressed the importance of virginity and suggested that romance should occur only after an engagement and should be 'public'. When relationships came back into the open the community could keep an eye on it (Gaitskell, 1982: 345; Healy-Clancy, 2013: 94, 106, 107; Lewis, 1992; Marks, 1987: 23; 1989: 228; Porterfield, 1998: 229, 230; Ulwazi, 2014b). There is a strong resemblance between the Bantu Purity League and the contemporary virginity testing groups.

As in the promotion of medical male circumcision, promoters of virginity testing did not promote virginity testing as a new practice but instead spoke of the reintroduction of a 'tradition'. Therefore the practice comes with an automatic level of legitimation because it is 'of the past' (McNeil, 2011: 27). The 'invention of tradition' (Hobsbawm & Ranger, 1983) is a political tool to manipulate support for a newly introduced practice by presenting it as a long lost 'tradition' (Spiegel & Boonzaier, 1988: 48, 53, 54, 57). The practice of virginity testing is not spoken about as a continual 'tradition'; something that is 'sacred' because it has always been practiced. Instead it is promoted as a practice that had been interrupted by the arrival of the Europeans. The emphasis on the forced interruption functions to awaken activism and African pride. It also suggests that the 'tradition' did not fade away, because it was no longer relevant, but because it was ended forcefully. This concept is visualised in Figure 30:

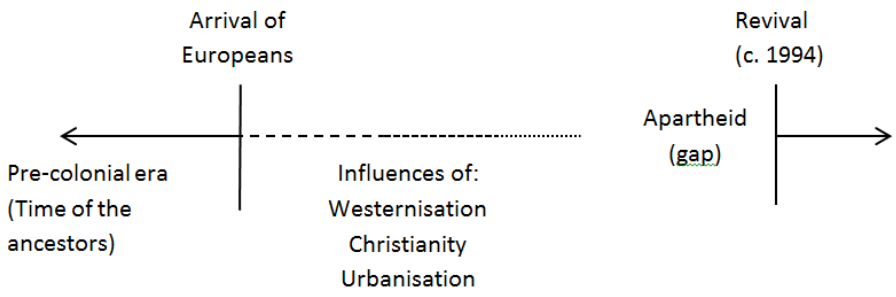

Figure 30: Schematic representation of historic trajectory of virginity testing (Scorgie, 2003: 66)

Those who promote virginity testing argue that the practice is still relevant today. They suggest that current unrest and ills are the result of western influences and their solution is to return to the pre-colonial practice of virginity testing. They want to go back to the period when, according to their memory, life was pristine and stable (Vincent, 2006: 27). This is in line with President Mbeki's 'African renaissance', referred to in chapter 1. To overthrow the colonial stereotype of Africans in need of the west, he promoted the use of African solutions to African problems, tailor-made solutions that fitted the South African context (Leclerc-Madlala, 2001b: 534, 536; McNeil, 2011: 30; Posel, 2005: 148; Thornton, 2008: 181). Hence, by emphasising virginity testing as a practice 'of the past', it seemed innate, legitimate, or culturally appropriate. This increased the chances of virginity testing being accepted as a normative practice (Leclerc-Madlala, 2001b: 538; 2003: 17, 20; McNeil, 2011: 27).

Despite being promoted as the revival of 'tradition' there is uncertainty about the actual origins of routine virginity testing. Scorgie states that virginity testing was common in Zulu households in pre-colonial times (2002: 57). She explains that girls would either be tested together at the homestead of the local chief by an appointed female tester, or they would be tested at their own homes by their mothers and grandmothers (Scorgie, 2002: 61). Leclerc-Madlala has her doubts about routine virginity testing going this far back into history; she does, however, acknowledge that virginity testing has roots in pre-colonial times (2001b: 543). Historical sources, for instance, emphasise the high value of female virginity when describing the extra head of cattle added to *lobolo* (bride wealth) for a virgin bride. Furthermore, during the puberty rituals girls were taught about the importance of 'protecting their father's cattle', and the *amaqhikiza* (peer advisers) taught their peers about the *ukusoma* (intercrural sex) practice (Leclerc-Madlala, 2001: 544). Each of these practices has been discussed in detail in chapter five on sexual socialisation. Leclerc-Madlala mentions another practice, which has not featured in the chapter on sexual socialisation. This is the practice of *ukushikila* (exposing buttocks). As part of this practice a girl was asked by an adult family member to lift her skirt to show her private area both at the front and the back. This practice supposedly existed to assess a girl's physical maturity and to establish if a girl was ready for marriage (Leclerc-Madlala, 2001b: 544; 2003: 19). None of these practices directly describe virginity testing, but they do highlight a long 'tradition' of female virginity being treasured and pre-marital sexual behaviour being strictly regulated (Leclerc-Madlala, 2001b: 543; 2003: 18; Scorgie, 2002: 61; Wickström, 2010: 534). Similar to the practice of virginity testing, the historical existence of the royal reed dance is also debatable. Even the exact moment it was

revived is unclear. Leclerc and McNeil state that the ceremony was re-introduced in 1991 (Leclerc-Madlala, 2005: 852; McNeil, 2011: 27), the South African News Agency declares that the ceremony was established in 1984 (SA news, 2009), and Scorgie states that the reed dance was revived in the late 1980's (Scorgie, 2003: 3). The actual historical existence of virginity testing and the royal reed dance is ultimately irrelevant when the promoters have successfully created an image of antiquity and sacredness. As a result the public considers virginity testing as a culturally appropriate practice and therefore individuals feel that they can implement it. Hence, for a practice to be considered 'traditional' it does not actually have to be historic; it could have been recently created, as long as a feeling of antiquity is successfully established (Anderson, 1983: 44; Hobsbawm & Ranger, 1983: 1). By borrowing elements from the "official ritual, symbolism and moral exhortation" of the past, new 'traditions' can create a feeling of antiquity (Hobsbawm & Ranger, 1983: 6). The status of a newly introduced practice is enhanced by presenting it as a long lost 'tradition' (Spiegel & Boonzaier, 1988).

A link to antiquity generally implies that the practice has been unchanged since its inception. Yet, the historical overview of both virginity testing and male circumcision illustrates that neither of these practices have been static throughout different generations. The contemporary practice that has emerged after a period of abandonment is not the same as the pre-colonial practice. The latest version of virginity testing in which large numbers of girls gather in sports stadiums to listen to speeches about HIV and to eventually walk out with a bought certificate proving their virginity, is different from the testing that was done at the local chief's homestead by an appointed tester (Leclerc-Madlala, 2003: 19; Vincent, 2006: 27). Similarly, the contemporary version of medical male circumcision which revolves around HIV prevention and takes place at the governmental clinics is different from the circumcision schools that were associated with the transition to manhood and took place in seclusion. The reality in which virginity testing was once practiced has changed over time. As a result the practice would no longer be applicable, unless it is adapted (Vincent, 2006: 27). "Pragmatic practices become 'customs' (…) But when everyday practices become rigidified into 'customs', these also become inscribed with meanings different to those originally intended. The same practice in a reinvented form inevitably takes shape against changing social contexts" (Scorgie, 2002: 63). Instead of an exact replica of the practice, relevant elements of the practice will be 're-tooled' into a 'modern' version of the practice (Wickström, 2010: 546). "Traditions (or culture or custom) constitute an adaptable resource

for coping with contemporary situations (...) customary institutional complexes are modified to meet contemporary needs" (Spiegel & Boonzaier, 1988: 53).

'Traditions' have long been perceived as static. Early anthropologists are largely responsible for this perception as they have in the past exclusively focused on describing the customs that participants explained were from prior western influence and ignored changing realities (Spiegel & Boonzaier, 1988: 44, 46). However, this thesis has demonstrated that 'traditions' are also dynamic and that they evolve over time. "Traditions (or culture or custom) constitute an adaptable resource for coping with contemporary situations (...) customary institutional complexes are modified to meet contemporary needs" (Spiegel & Boonzaier, 1988: 53). As such it is possible to introduce change. The limited flexibility of 'traditions' when it came to the implementation of condoms as opposed to the willingness to take on the altered versions of male circumcision and virginity testing demonstrates that the key is to borrow enough elements from historical "official rituals, symbolism and moral exhortation" so that the re-tooled practice can still create a feeling of antiquity to enhance the status of the practice (Hobsbawm & Ranger, 1983: 6). As mentioned earlier individual practice is most likely to follow the habitus, what an individual in its particular position is disposed to do. Over time these dispositions change to remain relevant. That is generally when an individual can apply new behaviour.

Traditionalists promote the practices of medical male circumcision and virginity testing as a return to 'tradition' suggesting a clear dichotomy between 'tradition' and 'modernity' (Eisenstadt, 1972: 1). However, as discussed in chapter five, Eisenstadt demonstrates how 'tradition' and 'modernity' are linked by pointing out 'traditional' elements in what is generally considered 'modern', and 'modern' elements in what is generally considered 'traditional'. The promotion of medical male circumcision could be understood in this way. By getting the Zulu King to launch the medical male circumcision campaign as a revival of 'tradition', a 'modern' intervention was framed "under the aegis of 'traditional' symbols and by 'traditional' elite" (Eisenstadt, 1972: 2). 'Traditions' are "often heavily spiced with cultural borrowings from the west" (Vincent, 2006: 27). [26] Several elements of 'modernity' can be found in the 'tradition' of virginity testing. First, "the quest for the authentic is in itself a 'modern' phenomenon" (Scorgie, 2003: 68). Second, the elaborate festival surrounding the

[26] As has been pointed out in chapter five, in the South African context the west is linked to' modernity', whereas 'traditions' are linked to African (Spiegel and Boonzaier, 1988).

so-called ‘traditional’ practice of virginity testing contains elements of mass entertainment, commercialism, and nationalism, concepts associated with ‘modernity’ (Kaarsholm, 2005: 147; Vincent, 2006: 27). Furthermore, Ngobese, who is a central person in the revival of virginity testing, drew on the work of mainly Western historians, ethnographers and missionaries as sources of information to reconstruct the pre-colonial past and formulate her ideas of the revival (Scorgie, 2003: 63).

8.5 Conclusion

This thesis studies the willingness and ability of community HIV educators to introduce HIV prevention in their personal lives. The previous chapter showed how the participants found the implementation of condom use challenging. In comparison, the alternative interventions addressed in this chapter seem to have been far more popular and easier to implement for the participants. If the lack of condom use was taken to mean a lack of interest in HIV prevention, than the enthusiastic uptake of these alternative HIV prevention interventions has proven that idea wrong and has showed that the participants were definitely interested in preventing HIV transmission.

So in comparison to condom use, what made these alternative interventions easier to implement? First, condoms needed to be implemented in the middle of the sexual experience. As such condoms impacted, and according to many participants spoiled, the sexual experience. The implementation of the three alternative interventions, however, was far removed from the actual sexual experience. HIV counselling and testing would take place in a medical set-up. When a couple was tested together the intervention enabled the couple to negotiate HIV prevention (only) in this clinical setting and keep their sexual interaction free from HIV associations. Also medical male circumcision would take place in a medical clinic. In the first six weeks the circumcision directly affected the sexual experience as men had to abstain. However, after this period, if anything, the sexual experience was rumoured to have improved. Clearly the intervention of virginity testing remained far removed from sexual experience as its members abstained.

Second, condom use required negotiation between sexual partners. According to the *hlonipha* custom it is inappropriate to discuss sexuality. Furthermore, according to gender roles men are in charge of making the sexual decisions. Obviously this severely limited the ability of a couple to negotiate the use of condoms. Negotiating HIV counselling and testing is experienced as easier to implement than condom use because it can be done prior to becoming sexually involved when a woman still has negotiating power. Furthermore it is

easier to discuss because it does not have the negative image that condoms have, and the discussion can avoid the link to sexuality, which according to the *hlonipha* custom cannot be discussed. The implementation of medical male circumcision is also experienced as easier to implement than condom use, because it is not dependent on a partner's compliance, which means that it does not involve any negotiation. A man can get circumcised prior to being involved with a woman. However, even for an existing couple negotiating medical male circumcision is easier than condom use, because medical male circumcision is positively linked to masculinity. The general perception is that it makes men out of boys, whilst also making men more popular with the women. Virginity testing is another individual solution. Women are aware of their subject position the moment they get involved with men. By declining any sexual advances, they remain in charge of their own sexual behaviour

Finally, another big difference between the implementation of condom use and the alternative interventions is that condom use was considered a foreign and inappropriate intervention that had to be regarded with suspicion, whereas the other interventions did not have to overcome negative associations and were instead perceived as local solutions and therefore culturally appropriate. This perception was the result of both successful marketing and unified political support. The strategic move to launch both medical male circumcision and virginity testing as revivals of classic 'traditions' successfully profiled the intervention as innate, antique, and familiar. Furthermore, the multi-level support for these interventions, which included both the government and traditional leaders, created a feeling of unity and commitment. This clear leadership left no room for confusion or suspicion which had been central to the intervention of condom use. As a result, medical male circumcision and virginity testing became part of the new normal, the normative discourse, the habitus and hence what people were disposed to do. This directly benefitted the ability of individuals to implement the alternative interventions. Similar to Bourdieu and Archer, I argue that the practice of an individual is not unmediated or mechanical, but neither is it completely controlled by the individual. For this reason an HIV prevention intervention does not only have to be considered acceptable by an individual, but also has to be generally accepted in the community. The fact that the alternative interventions became part of the normative discourse is why these interventions were easier to implement for the participants.

Chapter two has discussed Archer's perception that individuals consciously act strategically. Individuals consider structural properties that could impinge upon their 'project' and look for ways around these barriers to ensure that their projects still have the wanted

outcome, or, as a result of the adjustments, at least a ‘second-best outcome’. In the case of this thesis the project of the individuals, the community HIV educators, was HIV prevention. At the NGO they worked at, they were taught to use condoms to prevent HIV transmission. In the case of sexual interaction condoms provide the highest level of protection. This is therefore considered the best outcome of their project. Structural barriers, like gender inequality, kept several participants from implementing condom use, but some of these participants did negotiate HIV counselling and testing, whilst others got circumcised, or joined a virginity testing group. This could be considered the ‘second-best outcome’ to their HIV prevention project. These alternative interventions reduce the risk of HIV infection. Although condoms provide more protection than these alternative interventions, they can only do so when they are actually worn.

Chapter 9: Summary, conclusion and practical implications

This final chapter provides a summary of the thesis as a whole; it points out the key findings, and it closes with some practical implications of these key findings. To obtain insights into why certain HIV prevention interventions are easier to implement than others, this thesis has closely described the personal stories of thirty community HIV educators in KwaZulu-Natal. Compared to statistical studies this is a small number. It is a fact that these findings cannot be nationally or even provincially generalised with any certainty, but that has never been the objective of this study. Instead, the goal has been to describe the personal stories of this small group of participants, how they manage their relationships with the people around them and how they manage structural factors that affect the options available to them. It is this context which helps to explain why the participants make the decisions that they do. It is also this context that I believe is often overlooked by larger quantitative studies. Ultimately, I believe quantitative and qualitative research is mutually interdependent and should be combined in order to provide solid HIV prevention data.

The primary focus in this thesis has been on community HIV educators. Of these participants it could be stated from the outset that they were well informed about HIV prevention and depending on the specific NGO they worked for they have been at the receiving end of either 'female empowerment' or 'responsible masculinity' programmes. As a result studying the willingness and ability to implement HIV prevention practices of these particular individuals can contribute to answering the question of whether HIV awareness and gender-related programmes are sufficient to create HIV preventative behaviour change. It has been instructive to hear about the experiences of these particular participants as their experiences explain the enabling and restricting factors for implementation of such behaviour changes.

9.1 Early HIV interventions focus on individual HIV awareness and condom promotion

Initial HIV interventions in South Africa copied 'best practice' from Western countries, because the USA, Europe and Australia already had several years of experience dealing with the HIV epidemic and had been successful in limiting HIV transmission by primarily targeting individual responsibility and the use of condoms. This meant that initial South African HIV interventions promoted individual HIV awareness, according to the social cognition models, and emphasised the promotion of condoms. Compared to its success in

Western countries, the uptake of condoms in KwaZulu-Natal has not been as straight forward. During the early years of the epidemic condoms mainly had negative associations, linked to the apartheid government, discomfort, prostitution, a lack of trust, and AIDS. However, more recently the general consensus in the HIV prevention literature is that the initial negative attitude towards condoms in South Africa has been overcome and that condoms are now used by those who have received sufficient information about HIV. These condom-positive reports were initially confirmed by the participants of this study. However, during a later stage of the fieldwork the participants shared a more critical perspective on condom use. This thesis has given several examples of community HIV educators who do not consistently use condoms in their personal lives. This was a finding that initially surprised me because the situation of the participants met all the requirements of the social cognition models. First they had been provided with more than sufficient information on HIV prevention as a result of being trained as community HIV educators. Second on top of their factual knowledge they had also spoken of a personal transformation which had made them realise that they were responsible for their own health and wellbeing. When I thought of sex in South Africa I immediately thought of HIV transmission so I was surprised to find that this might not be the case for the participants. My surprise mainly reflected that my analysis of the behaviour of the participants had been influenced by my own habitus, which had been formed by growing up in the Netherlands where I was subjected to sexual education, HIV prevention campaigns like *ik vrij veilig of ik vrij niet* (I have safe sex or no sex), and as an HIV researcher I had done plenty of reading on the high HIV prevalence in South Africa and risky sexual behaviour. Coming from this background, it seemed illogical that individuals would not consistently use condoms. The thesis has been concerned mainly with trying to resolve this apparent illogicality.

9.2 The importance of seeing the participant's behaviour in context

Initially I believed that the lack of consistent condom use indicated an indifference towards HIV prevention, but as I came to understand the context in which the participants' sexual negotiations took place, I realised that indifference had little to do with inconsistent condom use. Being aware of these underlying issues helped me to understand why certain HIV prevention interventions were easier for the community HIV educators to implement than others. One context specific matter to be aware of is the sexuality taboo that affects the negotiation of HIV prevention and how this gradually increasing level of taboo has left a gap in the system of sexual socialisation, as discussed in chapter five.

Another issue that impacted on the behaviour of the participants was gender inequality. This thesis and chapter six in particular, has described how gender roles affect HIV prevention negotiations. According to these gender roles women are in control of decision making during courting and men take over when women have accepted their proposal. As of that moment women are expected to be submissive and refrain from criticism of their male partners. This male dominance and female submissiveness also affects sexual decision making.

Another relevant matter that affected the behaviour of the participants was financial hardship and the impact this could have on HIV risk behaviour. Due to the inability to finance marriage, many young people replaced marriage with the practice of multiple concurrent relationships, or they have chosen to have children out of wedlock. Both alternative practices enable men to compile symbolic capital from their male peers by showing that they are desired by the ladies and fertile. Women are also able to accumulate capital, in their case economic capital, through these practices. From an HIV transmission perspective, what is particularly 'risky' about these relationships is the secrecy that surrounds them, as the other party is supposed to think that they are in an exclusive relationship, see chapter six.

Finally, this thesis has pointed out how the existence of multiple discourses also affects the implementation of HIV prevention. Chapter seven has described how the participants spoke about condoms differently depending on the field of activity they were participating in. Whereas the actual use of condoms was confirmed and promoted in the professional field, amongst their peers in the public field the participants spoke of condoms with rejection, and in the domestic field the topic of condom use was left unspoken. Each of these discourses was weighing down on an individual's decision to negotiate or implement the use of condoms.

9.3 Structural factors influence individual practice

According to the logic of the social cognition model it was expected that if individuals were informed about HIV, were aware that the use of condoms could prevent HIV transmission, and realised that they were in charge of their own circumstances, they would put their learned behaviour into practice. The participants 'ticked all of these boxes', yet not all of them consistently used condoms. This thesis has turned to practice theorists like Bourdieu to explain why these individuals did not necessarily implement HIV preventative behaviour change. As described in chapter two, Bourdieu argues that even though it is the individual that acts, what the individual chooses to do is heavily influenced by structure. External structures are internalised by individuals through dispositions and practice follows on from

these dispositions, or what Bourdieu calls habitus. Hence, although the implementation of HIV prevention seems to be an individual project, it is habitus and therefore structure that influences the practice of the individual. On top of habitus, an individual's practice is also influenced by what Bourdieu calls field, as the field is a social space made up of positions which each come with a particular habitus. Interaction between individuals in the field is determined by their positions in relation to each other, as positions are hierarchically arranged. Related to the concept of field is the concept of capital. The position that an individual takes in the field is determined by the amount of capital the individual possesses compared to others in the same field. This can be economic, cultural, social or symbolic capital. When applying this idea to the case of HIV preventative behaviour in KwaZulu-Natal, an individual might know that HIV transmission can be prevented through the use of condoms, but when the use is not part of what an individual is disposed to do it can be hard for an individual to implement condom use. The level to which individual practice is influenced by structural factors depends on an individual's position. Those who have access to capital might be able to introduce change and implement condom use, or implement alternative HIV prevention strategies.

9.4 Collective perception change can enable individuals to implement HIV prevention

Implementing Bourdieu's insights into HIV prevention interventions suggests that instead of providing individual HIV awareness, HIV prevention interventions should attend to structural factors that influence the practice of individuals as part of particular socio-cultural groups. Hence interventions should focus on changing collective perceptions in support of HIV prevention strategies. When particular HIV prevention behaviour is part of normative discourse it becomes easier for individuals to implement. Chapter three has described how both NGOs at the centre of this thesis realised that individual HIV awareness failed to lead to behaviour change as long as contemporary gender roles and cultural 'traditions' discouraged the recommended HIV prevention initiatives. 'Women and Children First' addressed gender inequality through female empowerment. They encouraged women to overcome their dependency on men for the provision of capital. The NGO believes that independence enables women to take control of sexual decision making. The 'Bafana AIDS Project' on the other hand addressed gender inequality by directing their services towards men and tried to establish a responsible masculinity which allowed for HIV preventative behaviour.

To illustrate how the focus on collective change has better results at reducing HIV transmission than individual awareness, chapter three compared the early HIV prevention initiatives in Botswana with those in Uganda. Botswana followed the advice from the international public health community and as a result their individual-aimed, condom-centered, and top-down applied interventions failed to have the desired outcome. Uganda's approach was different. Their interventions were promoted through mass mobilisation, which meant that a large number of people came 'on board' and were committed to the cause. This cause aimed at transforming the collective norm in support of HIV preventative behaviour, which in turn was expected to encourage individual HIV prevention behaviour. Uganda's successful HIV prevention policy also demonstrated how HIV intervention could benefit from less fixation on condom use. Instead Uganda promoted local HIV prevention strategies, which were well-received. Initially South Africa's HIV prevention interventions resembled Botswana's approach and like Botswana these interventions failed to lead to behaviour change on a large scale, as has been explained in chapters one, three, and seven. However, chapter eight has described how more recently South Africa's HIV interventions (as introduced by President Zuma in 2010) have resembled Uganda's approach. These interventions, which were focused on changing the collective frame of mind, received committed support from political and cultural leaders and were no longer solely focused on condom promotion. This has seen a better uptake in the implementation of HIV preventative behaviour.

9.5 Agency and second best outcome

As indicated above this thesis has argued for the importance of acknowledging the impact of structural factors on individual behaviour and therefore it would be advisable for interventions to be aimed at influencing group behaviour that is influenced by these structural factors. However, this is not the complete argument. Despite the severe impact that structure can have on an individual's practice, it does not necessarily determine it. The individual does not act mechanically. Within structural constraints individuals have agency and are able to choose among alternatives as well as to introduce change. Individuals exercise agency in their attempt to prevent HIV transmission to the best of their ability. They are often strategic improvisers who obey a rule only insofar as their interest in following it outweighs their interest in overlooking it. There are various theories on how individuals achieve this. According to Bourdieu it is not a conscious process; instead individuals respond dispositionally to the opportunities and constraints offered by various situations. Bourdieu

uses the concept of habitus to explain how inculcated dispositions predispose a person to strive towards the position he or she is objectively most likely to attain. Archer, however, argues for a more conscious process. She states that individuals reflect upon the structural properties that are impinging on their projects or their intended course of action through internal conversations. When the constraints have been identified the individual can evaluate how best to realise the project in these circumstances. This could either be by looking for ways around the barriers or by adjusting the project to strive for the second-best outcome. The 'project' of the community HIV educators was HIV prevention. Condoms provide the highest level of protection against the sexual transmission of HIV and therefore the implementation of condom use could be considered the best outcome of the HIV prevention 'project'. Chapter eight has demonstrated how several participants, who were kept from implementing condom use by structural barriers, were able to negotiate HIV counselling and testing with their partners. In this case HIV counselling and testing could be considered the second best outcome to the HIV prevention 'project'. Although as an HIV prevention strategy the efficacy of condom use is higher than that of HIV counselling and testing, condoms only work when they are actually worn. The improvisation shown by these participants represents individuals who consciously reflect on their situation and aim to achieve the best results within the structural restrictions affecting their practice. The fact that participants have turned to alternative strategies to reduce the risk of HIV transmission in their personal lives also demonstrates that they do not feel indifferent towards preventing HIV transmission.

Chapter eight has also answered the question why HIV counselling and testing is easier to negotiate than condom use. First, there is a difference in timing. Condom use has to be implemented during the sexual act, whilst HIV counselling and testing can take place long before the sexual act. Consequently, condoms interrupt the sexual experience and colour it with HIV associations, whereas HIV counselling and testing does not. The difference in timing also makes for a difference in the level of negotiating power a woman has. As mentioned earlier, whereas women can state their demands prior to getting involved, the moment they accept a man's proposal he takes over sexual decision making. This means that it is easier for a woman to request an HIV test prior to getting involved than it is for her to mention condoms during sexual activity. Second, the use of a condom is believed to reduce pleasure, it obstructs intimate flesh to flesh contact, and it works as a contraceptive on top of preventing HIV transmission. All of this is not the case with HIV counselling and testing. Third, due to events in the past, condom promotion has had to deal with negative

connotations from the outset, whereas the promotion of HIV counselling and testing did not have to overcome the same level of negativity.

9.6 Discreet indiscretions

Throughout the thesis the concept of *hlonipha* (expressing respect through avoidance) has been described as an important concept in Zulu culture, see chapters four, five, six and seven. Central to the concept is concealment which signifies care and respect. *Hlonipha* also plays an important role in the implementation of change. When individuals deviate from ideal behaviour they do so discreetly. This way their behaviour will not stand out and therefore they can still be perceived as respectful. Hence, inappropriate behaviour can be condoned when it takes place in a discreet manner. This thesis has given several examples of what I have referred to as discreet indiscretions, a term borrowed from Bergmann (1993). One example was the unmarried couple who live separately but have a child together. Chapter six described how the boyfriend should not be seen visiting his girlfriend and his child, but how at the same time he is expected to provide for his child. When the couple behaves according to these adjusted guidelines, the fact that they have a baby outside wedlock can be condoned. Another example of discreet indiscretion, also described in chapter six, is 'respectful cheating'. When a boyfriend cannot act according to the ideal of being faithful, he should follow adjusted guidelines. In this case a cheating boyfriend should have his second relationship outside the community to avoid the humiliating situation in which his girlfriend is told about his extra relationship by someone in her social network. Finally, it has long been considered inappropriate for parents to talk to their children about sexuality or for partners to negotiate sexual matters. However, as a result of the pressing issue of the HIV epidemic parents or partners have found themselves needing to discuss sexuality. Chapters five and eight have shown that the most respectful way of doing this is by changing their subject position, for example by speaking as if they were peers.

9.7 Structural factors facilitating HIV prevention

This thesis has explained in detail how structural factors incline an individual's practice. When discussing the implementation of condom use in chapter seven, structural factors have been described as restricting or discouraging HIV preventative behaviour. However, besides a constraining influence, structural factors can also have an enabling influence. As outlined in Chapter two, Archer (2003) has argued that it is the relationship between the structural properties and the individual's project that will determine the influence of the structural

properties on the project. When it comes to alternative HIV prevention strategies like medical male circumcision and virginity testing, the same structural factors that discouraged the use of condoms actually encouraged the implementation of HIV prevention practices. Individuals follow what is generally perceived as appropriate action and chapter eight has argued that medical male circumcision and virginity testing have therefore been presented as such.

The promotion of condoms has seen resistance due to its negative associations and impracticality. What also played a role in this resistance was that condoms were considered a foreign solution that therefore did not have a place in Zulu culture. The moment the general opinion branded condoms as inappropriate, it became hard for an individual to implement their use. Arguably, with this in mind, when medical male circumcision and virginity testing were promoted in KwaZulu-Natal, effort went into presenting these interventions as locally initiated and collectively approved. In order to achieve this, the Zulu King, the President, and the Premier of KwaZulu-Natal, all Zulu men, were involved in the launch of these programmes. Instead of distancing themselves from these interventions these leaders expressed their support and spoke publicly about their personal experiences with these interventions. This avoided the confusion, suspicion, and resistance that had been characteristic of the response to the promotion of condoms. To create the image that the interventions were locally initiated and collectively approved the practice of medical male circumcision and virginity testing were promoted as a revival of 'tradition'. This created a feeling of antiquity, familiarity, and legitimacy, which enhanced the status of the two practices. It made the practices appear culturally appropriate. Returning to 'tradition' became an especially vital political tool for those who believed that it was the transgression of 'traditional' sexual norms that had enabled the spread of HIV. Hence, according to this ideology AIDS was a punishment for immorality and a return to 'tradition' could counteract this process.

This thesis has argued in chapter eight that the so-called revival of 'tradition' can have its desired effect, even when technically it can be questioned whether the current practices of medical male circumcision and virginity testing are actually revived 'traditions'. In chapter five it was demonstrated that although the word 'tradition' is associated with antiquity, for something to be described as 'tradition' it does not necessarily have to have a solid historical backing. Practices considered 'traditional' could be recently established practices linked to 'modernity'. As long as it is experienced as if the 'tradition' was established a long time ago and therefore a feeling of antiquity is successfully established, it does not matter how long

ago the practice was actually established. Furthermore, the word 'tradition' is associated with authenticity and being fixed. This suggests that 'traditional' customs have not changed since their inception and therefore cannot be expected to change in the future. This thesis, however, has demonstrated that 'traditions' are not static, resistant to change, or unaffected by 'modernity'. Instead 'traditions' have adapted over time in response to social change. The contemporary version of medical male circumcision conducted at the clinic is different from the circumcision schools that existed before Shaka abolished them. Similarly, the latest version of virginity testing in which large numbers of girls gather in sports stadiums to listen to speeches about HIV and to eventually walk out with a bought certificate proving their virginity is different from the testing that was once done at the local chief's homestead by an appointed tester. Ultimately 'tradition' and 'modernity' influence each other. There are 'traditional' elements in what is generally considered 'modern' and 'modern' elements in what is generally considered 'traditional'. The contemporary versions of medical male circumcision and virginity testing are not exactly like they once were, but neither are they completely 'modernised'. Although 'traditions' have changed as a result of modernisation, 'modernity' is integrated, rejected and reinterpreted by the local community. Consequently, despite the worldwide impact of modernity, there cannot be one homogenous 'modern' society, instead there are 'multiple modernities', a term borrowed from Eisenstadt (2000).

9.8 Conclusion

In summary the answer to the core research question, how do community HIV educators in KwaZulu-Natal negotiate HIV prevention in their everyday intimate relationships, is as follows: The thesis has emphasised how the practice of an individual is heavily impacted by structural factors. This means that the negotiation of HIV prevention is affected by what is generally considered appropriate in terms of existing dispositions. This can have a restricting effect on the negotiation of HIV prevention, which has been the case with gender inequality and the taboo around discussing sexuality restricting the negotiation of HIV prevention between couples. At the same time the thesis has also shown how structural factors had an encouraging effect on particular HIV preventative strategies. However, structural factors impacting individual practice is not the complete story. This thesis has also attended to individuals deviating from collectively determined ideal practice. In the latter case HIV prevention is negotiated discreetly.

9.9 Practical implications

The reason for initiating this research is because I believed that these community HIV educators were holding key information that could help reduce HIV transmission in their area, and that they also held more general information that policy makers should be aware of before setting up interventions. Believing in the importance of having their stories heard, I decided to record the life stories of these community HIV educators with the aim to bring them to the attention of national and international HIV prevention policymakers. As an anthropologist I believed I could contribute by mediating between the field of the participants and the field of the policymakers. Throughout the research I became aware of the extent to which my habitus affected what I saw and how I interpreted these findings. The bias was there despite my sincere intention to arrive in the research area without presumptions. This thesis has aimed to highlight how outsiders, in particular policymakers, need to be aware of their habitus and come to understand that they cannot merely use their personal compass to determine what interventions will bring about behaviour change. Interventions need to be based on consultation with local communities and the following summarises what consultation with the people 'on the ground' has taught me.

Merely because individuals have been provided with HIV prevention information, including condom promotion, does not mean that they can be expected to implement condom use. There are a variety of reasons that can restrict individuals from implementing condom use. Conventional Zulu gender norms place men in charge of sexual decision making, which hinders the open discussion of sexual matters. Furthermore, the lack of sexual socialisation has left individuals without a template on how to talk about sexual matters. Condoms are also generally perceived as a nuisance, uncomfortable and interruptive. Although political and cultural leaders have supported other strategies for tackling the HIV epidemic, they have failed to express their support for the use of condoms. This has contributed to the general perception of condom use as inappropriate behaviour. The associations with casual sex do not help to counter this perception. Instead condoms are perceived as out of place in long term relationships and are linked to a lack of trust when they are suggested. Another factor that makes it difficult to negotiate the use of condoms is that it requires negotiation to take place in the bedroom instead of prior to the start of a sexual relationship.

All of these factors affect the ability of an individual to bring up the topic of condom use with a sexual partner. The individual might understand that using a condom could prevent HIV transmission, but the individual has to consider what the consequences will be when he

or she suggests something considered inappropriate. The implementation of HIV prevention is not an individual matter; instead, individuals act in relation to others. Hence, it is not about convincing an individual of how certain practices could prevent HIV transmission, but about making these practices considered generally appropriate. In the latter case an individual feels enabled and supported to implement the practice.

Nevertheless, an increase in capital (be it economic, cultural, social, or symbolic) can suppress the effect of structural factors and enable individuals to deviate from practices deemed appropriate. This was the case with the participant who left her cheating husband. She could afford to do so because she had her own income to provide for her children and felt supported by an extensive social network that did not rely on her being a married woman. Hence, besides making HIV prevention practices deemed appropriate by the collective, intervention can also aim at increasing the economic, cultural, social, and symbolic capital of individuals so that they can afford to deviate from generally approved behaviour.

Another matter that emerged from this research is that instead of being fixated on enforcing foreign solutions, it is more constructive for policymakers to listen to solutions suggested by the people at the centre of their interventions. When condom promotion is presented as the only right thing to do, then it is unlikely that people feel free to speak of anything else. Only near the end of this research did some of the participants share stories that contradicted the condom-positive discourse. These participants explained how instead of negotiating condom use, they discreetly negotiated HIV testing with their sexual partners. The participants experienced HIV testing as easier to implement than condom use. HIV prevention is a strategy that does not affect the sexual experience because it takes place in a medical setting prior to becoming sexually involved. In addition, HIV testing has not been faced with the same negative associations and lack of collective support as condom use has. It would be advisable to listen to suggestions from 'the ground' and for interventions to help facilitate these suggestions. When people 'on the ground' make it known that HIV counselling and testing has potential, then this should be encouraged. This is exactly what President Zuma has done since 2010. Together with other political leaders he has normalised HIV testing by taking public HIV tests. The next step would be to normalise not just individual but also couple testing. Due to particular gender roles and a lack of sexual socialisation, couples struggle to discuss sexual matters in the domestic sphere. However, when they can meet in a different setting where the rules for interaction have not yet been determined and where there is a counsellor who can facilitate the discussion, this might make it easier for a couple to talk

and make a plan of action for HIV prevention without upsetting the everyday power balance. It also carefully gets them used to talking about sexuality with a sexual partner. This thesis has stressed that HIV testing will have most impact as a prevention tool when it is offered in combination with quality pre and post-test counselling.

The recent practice of virginity testing has also been started by people 'on the ground'. It is experienced by the girls involved as an empowering event. The number of girls involved in virginity testing form a minority. This means that girls are likely to feel pressured by their general peers to gain sexual experience. Consequently, when they can meet with girls who also have decided to abstain until they have, for instance, finished their studies, they feel supported in their lifestyle decision. Furthermore, during these group gatherings there is an opportunity to mend the gap of sexual socialisation by including the discussion of HIV prevention strategies. As a result when these girls are no longer interested in abstinence, they are well-informed and equipped for what is to come.

There are also solutions that have initially been suggested by foreign institutions, but for which the promotion has been handed over to local, cultural, and political leaders. This was to avoid the intervention being perceived as a foreign solution, a factor identified as having a negative impact when it came to the promotion of condom use. An example of a local institution taking control over a 'foreign' solution is when the WHO released findings that medical male circumcision could reduce the risk of HIV infection. In KwaZulu-Natal this international suggestion was made to feel indigenous by framing medical male circumcision as a revival of 'tradition'. In Faras the founder of the 'Bafana AIDS Project' arranged for a meeting with local community representatives. She asked them for their thoughts on the proposed practice of medical male circumcision, how they would feel if the practice was promoted at the local clinic and if they could foresee problems. Instead of merely informing them on what was going to happen, she got them involved in the preparation. As a result collective approval followed, which made it easier for individuals to put the practice of medical male circumcision into practice.

Overall, the above has shown how certain approaches facilitate behaviour change, whereas other approaches are more likely to lead to stagnation.

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